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LEGISLATIVE HISTORY TITLES I-XX OF THE SOCIAL SECURITY ACT

VOL. XVIII
95th CONGRESS
1977-1978

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Legislative History of Titles I-XX of the Social Security Act

Volume XVIII
95th Congress
1977-1978

Compiled by the
Technical Documents Branch
Division of Technical Documents and Privacy
Office of Regulations
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PREFACE

This legislative history has been expanded to include enactments during the 95th Congress involving any of the 20 titles of the Social Security Act. Previously, the legislative history which began with the Social Security Act, as enacted on August 14, 1935, pertained only to the benefit programs (titles II, XVI, and XVIII) administered by the Social Security Administration. Now that the administrative purview of the Social Security Administration has been extended, the legislative history has been accordingly expanded.

This legislative history includes:

- Every enactment of the 95th Congress affecting or adding to the provisions of the Social Security Act.
- Relevant committee reports of the House of Representatives and the Senate relating to the Social Security Act. Where pertinent, excerpts may be substituted for a full text.

In some instances the House and Senate reports accompanying a particular act will not reflect one or more provisions contained in the act. This is usually due to the fact that the particular provision was added to the bill on the floor of the House, or Senate, as the case may be, after issuance of the particular report. In these cases, background material relating to the amendment may be found in the Congressional Record report of the House or Senate debate on the bill. The Congressional Record may also provide a useful supplemental reference source even in those cases in which the House or Senate report discusses the particular provision in which the researcher is interested. It is not feasible to reproduce in this legislative history the thousands of pages of the Congressional Record carrying the House and Senate debates with respect to the acts included in the history. However, on the last page of each public law contained in this volume, appears a listing of the dates on which the act was considered in the House and Senate, and the volume of the Congressional Record in which such debate may be found.

The material included in this
legislative history is an
exact photo-reproduction of
the original documents.

READEX FICHE
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Finder's Aid

P.L. 95-30 (91 Stat. 126) Approved May 23, 1977
Tax Reduction & Simplification Act of 1977

Subject	SS Act Section	P.L. Sec.	91 Stat.	H.Rep. 95-27-I	H.R. 95-27-II	S.Rep. 95-66	C.H.Rep. 95-263
Provides Bonding for Employees with Cash	454	502(a)	162	—	1-2	—	35
Incentive Pay To Localities	458	503	162	—	1-2	—	35
Garnishment Provisions	459	501	157	—	1-2	—	35
Authority for Regulations re Garnishment	461	501(c)	158	—	1-2	—	35
Definition of Terms	462	501(d)	159-161	—	1-2	—	35

pages tightly bound

PUBLIC LAW 95-30—MAY. 23, 1977

TAX REDUCTION AND SIMPLIFICATION ACT OF 1977

Public Law 95-30
95th Congress

An Act

May 23, 1977
[H.R. 3477]

To reduce individual and business income taxes and to provide tax simplification and reform.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Tax Reduction and Simplification Act of 1977.
26 USC 1 note.

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) Short Title.—This Act may be cited as the "Tax Reduction and Simplification Act of 1977".

(b) Table of Contents.—

Sec. 1. Short title; table of contents.
Sec. 2. Amendment of 1954 Code.

TITLE I—REDUCTION AND SIMPLIFICATION OF INDIVIDUAL INCOME TAXES

Sec. 101. Change in tax rates and tax tables to reflect permanent increase in standard deduction.
Sec. 102. Change in definition of taxable income to reflect change in tax rates and tables.
Sec. 103. Extension of individual income tax reductions.
Sec. 104. Change in filing requirements.
Sec. 105. Withholding tax.
Sec. 106. Effective dates.

TITLE II—REDUCTION IN BUSINESS TAXES

Sec. 201. Extension of certain corporate income tax reductions.
Sec. 202. New jobs credit.

TITLE III—PROVISIONS RELATING TO EFFECTIVE DATES AND OTHER PROVISIONS OF THE TAX REFORM ACT OF 1976

Sec. 301. Effective date of changes in the exclusion for sick pay.
Sec. 302. Changes in treatment of income earned abroad by United States citizens living or residing abroad.
Sec. 303. Underpayments of estimated tax.
Sec. 304. Underwithholding.
Sec. 305. Interest on underpayments of tax.
Sec. 306. Use of residence as day care facility.
Sec. 307. State legislators' travel expenses away from home.
Sec. 308. Treatment of intangible drilling costs for purposes of the minimum tax.
Sec. 309. Transfers of partial interests in property for conservation purposes.

TITLE IV—MISCELLANEOUS PROVISIONS

Sec. 401. Authorization of additional appropriations for the work incentive program.
Sec. 402. Rapid amortization of child care facilities.
Sec. 403. Election of former retirement income credit provisions for 1976.
Sec. 404. Postponement of effective date of changes made by the Tax Reform Act of 1976 in the method of accounting for certain corporations engaged in farming.
Sec. 405. Withholding tax on certain gambling winnings.
Sec. 406. Termination of 1975 special payments to certain individuals.
Sec. 407. Payments to the governments of American Samoa, Guam, and the Virgin Islands.
Sec. 408. Withholding of county income tax on Federal employees.

TITLE V—CERTAIN SOCIAL SECURITY ACT AMENDMENTS

Sec. 501. Clarification of garnishment provisions.
Sec. 502. Bonding of certain State or local employees; handling of cash receipt
Sec. 503. Incentive payments to States and localities.
Sec. 504. Annual report of the Secretary.
Sec. 505. Certain AFDC payments.

SEC. 2. AMENDMENT OF 1954 CODE.

Except as otherwise expressly provided, whenever in this Act a amendment or repeal is expressed in terms of an amendment to, o repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenu Code of 1954. 26 USC 1 *et seq.*

TITLE I—REDUCTION AND SIMPLIFICATION OF INDIVIDUAL INCOME TAXES

SEC. 101. CHANGE IN TAX RATES AND TAX TABLES TO REFLECT PERMANENT INCREASE IN STANDARD DEDUCTION.

26 USC 1. (a) CHANGE IN TAX RATES.—Section 1 (relating to tax imposed) is amended to read as follows:

"SECTION 1. TAX IMPOSED.

"(a) MARRIED INDIVIDUALS FILING JOINT RETURNS AND SURVIVING SPOUSES.—There is hereby imposed on the taxable income of—

"(1) every married individual (as defined in section 143) who makes a single return jointly with his spouse under section 6013, and

"(2) every surviving spouse (as defined in section 2(a)),

a tax determined in accordance with the following table:

"If the taxable income is:	The tax is:
Not over $3,200	No tax.
Over $3,200 but not over $4,200	14% of the excess over $3,200.
Over $4,200 but not over $5,200	$140, plus 15% of excess over $4,200.
Over $5,200 but not over $6,200	$290, plus 16% of excess over $5,200.
Over $6,200 but not over $7,200	$450, plus 17% of excess over $6,200.
Over $7,200 but not over $11,200	$620, plus 19% of excess over $7,200.
Over $11,200 but not over $15,200	$1,380, plus 22% of excess over $11,200.
Over $15,200 but not over $19,200	$2,260, plus 25% of excess over $15,200.
Over $19,200 but not over $23,200	$3,260, plus 28% of excess over $19,200.
Over $23,200 but not over $27,200	$4,380, plus 32% of excess over $23,200.
Over $27,200 but not over $31,200	$5,660, plus 36% of excess over $27,200.
Over $31,200 but not over $35,200	$7,100, plus 39% of excess over $31,200.
Over $35,200 but not over $39,200	$8,660, plus 42% of excess over $35,200.
Over $39,200 but not over $43,200	$10,340, plus 45% of excess over $39,200.
Over $43,200 but not over $47,200	$12,140, plus 48% of excess over $43,200.
Over $47,200 but not over $55,200	$14,060, plus 50% of excess over $47,200.

"(B) **Excess intangible drilling costs.**—For purposes of subparagraph (A), the amount of the excess intangible drilling costs arising in the taxable year is the excess of—

"(i) the intangible drilling and development costs described in section 263(c) paid or incurred in connection with oil and gas wells (other than costs incurred in drilling a nonproductive well) allowable under this chapter for the taxable year, over

"(ii) the amount which would have been allowable for the taxable year if such costs had been capitalized and straight line recovery of intangibles (as defined in subsection (d)) had been used with respect to such costs.

"(C) **Net income from oil and gas properities.**—For purposes of subparagraph (A), the amount of the net income of the taxpayer from oil and gas properties for the taxable year is the excess of—

"(i) the aggregate amount of gross income (within the meaning of section 613(a)) from all oil and gas properties of the taxpayer received or accrued by the taxpayer during the taxable year, over

"(ii) the amount of any deductions allocable to such properties reduced by the excess described in subparagraph (B) for such taxable year."

(b) **Effective Date.**—The amendment made by subsection (a) shall apply with respect to taxable years beginning after December 31, 1976, and before January 1, 1978.

26 USC 57 note.

SEC. 309. TRANSFERS OF PARTIAL INTERESTS IN PROPERTY FOR CONSERVATION PURPOSES.

(a) **In General.**—Clause (iii) of section 170(f)(3)(B) (relating to exceptions from denial of deduction in case of certain contributions of partial interests in property) is amended to read as follows:

26 USC 170.

"(iii) a lease on, option to purchase, or easement with respect to real property granted in perpetuity to an organization described in subsection (b)(1)(A) exclusively for conservation purposes, or".

(b) **Effective Dates.**—

(1) The amendment made by subsection (a) shall apply with respect to contributions or transfers made after June 13, 1977, and before June 14, 1981.

26 USC 170 note.

(2) Paragraph (4) of section 2124(e) of the Tax Reform Act of 1976 is amended by striking out "June 14, 1977" and inserting in lieu thereof "June 14, 1981".

26 USC 170 note.

TITLE IV—MISCELLANEOUS PROVISIONS

SEC. 401. AUTHORIZATION OF ADDITIONAL APPROPRIATIONS FOR THE WORK INCENTIVE PROGRAM.

(a) **Matching Funds Disregarded.**—The Secretary of Health, Education, and Welfare and the Secretary of Labor are authorized to carry out the work incentive program under title IV of the Social Security Act from the sums appropriated pursuant to this Act without regard to the requirements for non-Federal matching funds contained in sections 402(a)(19)(C), 402(a)(19)(G), 403(a)(3)(A), 403(d), and 435 of the Social Security Act.

42 USC 602 note.

42 USC 601.

42 USC 602, 603, 635.

(b) Authorization.—There are authorized to be appropriated to carry out the work incentive program under title IV of the Social Security Act, as modified by this Act (in addition to any sums otherwise appropriated pursuant to title IV of such Act), $435,000,000 for fiscal year 1978 and $435,000,000 for fiscal year 1979.

42 USC 601.

SEC. 402. RAPID AMORTIZATION OF CHILD CARE FACILITIES.

(a) Rapid Amortization of Child Care Facilities.—

26 USC 188.

(1) Subsection (c) of section 188 (relating to application of section 188) is amended by striking out "January 1, 1977" and inserting in lieu thereof "January 1, 1982".

(2) Subsection (b) of section 188 (relating to definition of section 188 property) is amended by striking out "as a facility for on-the-job training of employees (or prospective employees) of the taxpayer, or".

(3) The caption of section 188 is amended by striking out "ON-THE-JOB TRAINING AND".

(4) The table of sections for part VI of subchapter B of chapter 1 is amended by striking out the item relating to section 188 and inserting in lieu thereof the following new item:

"Sec. 188. Amortization of certain expenditures for child care facilities."

26 USC 57.

(5) The caption of paragraph (10) of section 57(a) (relating to items of tax preference) is amended by striking out "ON-THE-JOB TRAINING AND".

26 USC 188 note.

(b) Effective Date.—The amendments made by subsection (a) shall apply with respect to expenditures made after December 31, 1976.

SEC. 403. ELECTION OF FORMER RETIREMENT INCOME CREDIT PROVISIONS FOR 1976.

26 USC 37 note.

26 USC 37.

26 USC 37.

A taxpayer may elect (at such time and in such manner as the Secretary of the Treasury or his delegate shall prescribe) to determine the amount of his credit under section 37 of the Internal Revenue Code of 1954 for his first taxable year beginning in 1976 under the provisions of such section as they existed before the amendment made by section 503 of the Tax Reform Act of 1976.

SEC. 404. POSTPONEMENT OF EFFECTIVE DATE OF CHANGES MADE BY THE TAX REFORM ACT OF 1976 IN THE METHOD OF ACCOUNTING FOR CERTAIN CORPORATIONS ENGAGED IN FARMING.

26 USC 447 note.

Section 207(c)(2) of the Tax Reform Act of 1976 is amended to read as follows:

"(2) Effective dates.—

"(A) In general.—Except as provided in subparagraph (B), the amendments made by paragraph (1) shall apply to taxable years beginning after December 31, 1976.

"(B) Special rule for certain corporations.—In the case of a corporation engaged in the trade or business of farming and with respect to which—

"(i) members of two families (within the meaning of paragraph (1) of section 447(d) of the Internal Revenue Code of 1954, as added by paragraph (1)) owned, on October 4, 1976 (directly or through the application of such section 447(d)), at least 65 percent of the total combined voting power of all classes of stock of such corpo-

Secretary of the Treasury upon certification to the Secretary by the United States Government Comptrollers for Guam and the Virgin Islands.

Appropriation authorization.

(b) There are hereby authorized to be appropriated, out of any funds in the Treasury not otherwise appropriated, such sums as may be necessary to carry out the provisions of this section.

SEC. 408. WITHHOLDING OF COUNTY INCOME TAX ON FEDERAL EMPLOYEES.

(a) IN GENERAL.—Section 5520 of title 5, United State Code, is amended—

(1) by inserting "or county" after "city" in the heading of such section;

(2) by inserting "or county" after "city" each place it appears in subsections (a) and (b) (other than in subsection (a)(1));

(3) by striking out "the city" in subsection (a)(1) and inserting in lieu thereof "a designated city or county officer, department, or instrumentality";

(4) by striking out "and" at the end of subsection (c)(1);

Definitions.

(5) by redesignating paragraph (2) of subsection (c) as (4), and by inserting after paragraph (1) of such subsection the following new paragraphs:

"(2) 'county' means any unit of local general government which is classified as a county by the Bureau of the Census and within the political boundaries of which 500 or more persons are regularly employed by all agencies of the Federal Government;

"(3) 'ordinance' means an ordinance, order, resolution, or similar instrument which is duly adopted and approved by a city or county in accordance with the constitution and statutes of the State in which it is located and which has the force of law within such city or county; and".

(b) CONFORMING AMENDMENT.—The table of contents of subchapter II of chapter 55 of title 5, United States Code, is amended by inserting "or county" after "city" in the item relating to section 5520.

5 USC 5520 note.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act.

TITLE V—CERTAIN SOCIAL SECURITY ACT AMENDMENTS

SEC. 501. CLARIFICATION OF GARNISHMENT PROVISIONS.

42 USC 659.

(a) IN GENERAL.—Section 459 of the Social Security Act is amended—

(1) by striking out "(including any agency or instrumentality thereof and any wholly owned Federal Corporation)" and inserting in lieu thereof "or the District of Columbia (including any agency, subdivision, or instrumentality thereof)"; and

(2) by inserting "or the District of Columbia" immediately after "United States" where it appears the second time.

(b) SERVICE OF PROCESS.—Section 459 of such Act is further amended—

(1) by inserting "(a)" immediately after "SEC. 459.", and

(2) by adding at the end thereof the following new subsections:

"(b) Service of legal process brought for the enforcement of an individual's obligation to provide child support or make alimony payments shall be accomplished by certified or registered mail, return receipt requested, or by personal service, upon the appropriate agent designated for receipt of such service of process pursuant to regulations promulgated pursuant to section 461 (or, if no agent has been designated for the governmental entity having payment responsibility for the moneys involved, then upon the head of such governmental entity). Such process shall be accompanied by sufficient data to permit prompt identification of the individual and the moneys involved.

Infra.

"(c) No Federal employee whose duties include responding to interrogatories pursuant to requirements imposed by section 461(b)(3) shall be subject under any law to any disciplinary action or civil or criminal liability or penalty for, or on account of, any disclosure of information made by him in connection with the carrying out of any of his duties which pertain (directly or indirectly) to the answering of any such interrogatory.

Notice.

"(d) Whenever any person, who is designated by law or regulation to accept service of process to which the United States is subject under this section, is effectively served with any such process or with interrogatories relating to an individual's child support or alimony payment obligations, such person shall respond thereto within thirty days (or within such longer period as may be prescribed by applicable State law) after the date effective service thereof is made, and shall, as soon as possible but not later than fifteen days after the date effective service is so made of any such process, send written notice that such process has been so served (together with a copy thereof) to the individual whose moneys are affected thereby at his duty station or last-known home address.

"(e) Governmental entities affected by legal processes served for the enforcement of an individual's child support or alimony payment obligations shall not be required to vary their normal pay and disbursement cycles in order to comply with any such legal process.

"(f) Neither the United States, any disbursing officer, nor governmental entity shall be liable with respect to any payment made from moneys due or payable from the United States to any individual pursuant to legal process regular on its face, if such payment is made in accordance with this section and the regulations issued to carry out this section.".

(c) REGULATIONS.—Part D of title IV of such Act is further amended by adding at the end thereof the following new section:

"REGULATIONS PERTAINING TO GARNISHMENTS

42 USC 661.
Ante, p. 157.

"SEC. 461. (a) Authority to promulgate regulations for the implementation of the provisions of section 459 shall, insofar as the provisions of such section are applicable to moneys due from (or payable by)—

"(1) the executive branch of the Government (including in such branch, for the purposes of this subsection, the territories and possessions of the United States, the United States Postal Service, the Postal Rate Commission, any wholly owned Federal corporation created by an Act of Congress, and the government of the District of Columbia), be vested in the President (or his designee),

"(2) the legislative branch of the Government, be vested jointly in the President pro tempore of the Senate and the Speaker of the House of Representatives (or their designees), and

"(3) the judicial branch of the Government, be vested in the Chief Justice of the United States (or his designee).

"(b) Regulations promulgated pursuant to this section shall—

"(1) in the case of those promulgated by the executive branch of the Government, include a requirement that the head of each agency thereof shall cause to be published, in the appendix of the regulations so promulgated, (A) his designation of an agent or agents to accept service of process, identified by title of position, mailing address, and telephone number, and (B) an indication of the data reasonably required in order for the agency promptly to identify the individual with respect to whose moneys the legal process is brought,

"(2) in the case of regulations promulgated for the legislative and judicial branches of the Government set forth, in the appendix to the regulations so promulgated, (A) the name, position, address, and telephone number of the agent or agents who have been designated for service of process, and (B) an indication of the data reasonably required in order for such entity promptly to identify the individual with respect to whose moneys the legal process is brought, and

"(3) provide that (A) in the case of regulations promulgated by the executive branch of the Government, each head of a governmental entity (or his designee) shall respond to relevant interrogatories, if authorized by the law of the State in which legal process will issue, prior to formal issuance of such process, upon a showing of the applicant's entitlement to child support or alimony payments, and (B) in the case of regulations promulgated for the legislative and judicial branches of the Government, the person or persons designated as agents for service of process in accordance with paragraph (2) shall respond to relevant interrogatories if authorized by the law of the State in which legal process will issue, prior to formal issuance of legal process, upon a showing of the applicant's entitlement to child support or alimony payments.

"(c) In the event that a governmental entity, which is authorized under this section or regulations issued to carry out this section to accept service of process, pursuant to the provisions of subsection (a), is served with more than one legal process with respect to the same moneys due or payable to any individual, then such moneys shall be available to satisfy such processes on a first-come, first-served basis, with any such process being satisfied out of such moneys as remain after the satisfaction of all such processes which have been previously served.".

(d) Definitions.—Part D of title IV of such Act is further amended by adding after section 461 (as added by subsection (c) of this section) the following new section:

"DEFINITIONS

"Sec. 462. For purposes of section 459— 42 USC 662.

"(a) The term 'United States' means the Federal Government of the United States, consisting of the legislative branch, the judicial branch, and the executive branch thereof, and each and every department, agency, or instrumentality of any such branch, including the United States Postal Service, the Postal Rate Commission, any wholly owned Federal corporation created by an Act of Congress, any office, 42 USC 659.

commission, bureau, or other administrative subdivision or creatur thereof, and the governments of the territories and possessions of th United States.

"(b) The term 'child support', when used in reference to the lega obligations of an individual to provide such support, means periodi payments of funds for the support and maintenance of a child or children with respect to which such individual has such an obligation, and (subject to and in accordance with State law) includes but is no limited to, payments to provide for health care, education, recreation clothing, or to meet other specific needs of such a child or children; such term also includes attorney's fees, interest, and court costs, whe and to the extent that the same are expressly made recoverable as such pursuant to a decree, order, or judgment issued in accordance with applicable State law by a court of competent jurisdiction.

"(c) The term 'alimony', when used in reference to the legal obligations of an individual to provide the same, means periodic payments of funds for the support and maintenance of the spouse (or former spouse) of such individual, and (subject to and in accordance with State law) includes but is not limited to, separate maintenance, alimony pendente lite, maintenance, and spousal support; such term also includes attorney's fees, interest, and court costs when and to the extent that the same are expressly made recoverable as such pursuant to a decree, order, or judgment issued in accordance with applicable State law by a court of competent jurisdiction. Such term does not include any payment or transfer of property or its value by an individual to his spouse or former spouse in compliance with any community property settlement, equitable distribution of property, or other division of property between spouses or former spouses.

"(d) The term 'private person' means a person who does not have sovereign or other special immunity or privilege which causes such person not to be subject to legal process.

"(e) The term 'legal process' means any writ, order, summons, or other similar process in the nature of garnishment, which—

"(1) is issued by (A) a court of competent jurisdiction within any State, territory, or possession of the United States, (B) a court of competent jurisdiction in any foreign country with which the United States has entered into an agreement which requires the United States to honor such process, or (C) an authorized official pursuant to an order of such a court of competent jurisdiction or pursuant to State or local law, and

"(2) is directed to, and the purpose of which is to compel, a governmental entity, which holds moneys which are otherwise payable to an individual, to make a payment from such moneys to another party in order to satisfy a legal obligation of such individual to provide child support or make alimony payments.

"(f) Entitlement of an individual to any money shall be deemed to be 'based upon remuneration for employment', if such money consists of—

"(1) compensation paid or payable for personal services of such individual, whether such compensation is denominated as wages, salary, commission, bonus, pay, or otherwise, and includes but is not limited to, severance pay, sick pay, and incentive pay, but does not include awards for making suggestions, or

42 USC 428. "(2) periodic benefits (including a periodic benefit as defined in section 228(h)(3) of this Act) or other payments to such individual under the insurance system established by title II of this

42 USC 401.

Act or any other system or fund established by the United States (as defined in subsection (a)) which provides for the payment of pensions, retirement or retired pay, annuities, dependents or survivors' benefits, or similar amounts payable on account of personal services performed by himself or any other individual (not including any payment as compensation for death under any Federal program, any payment under any Federal program established to provide 'black lung' benefits, any payment by the Veterans' Administration as pension, or any payments by the Veterans' Administration as compensation for a service-connected disability or death, except any compensation paid by the Veterans' Administration to a former member of the Armed Forces who is in receipt of retired or retainer pay if such former member has waived a portion of his retired pay in order to receive such compensation), and does not consist of amounts paid, by way of reimbursement or otherwise, to such individual by his employer to defray expenses incurred by such individual in carrying out duties associated with his employment.

"(g) In determining the amount of any moneys due from, or pay-ble by, the United States to any individual, there shall be excluded mounts which—

"(1) are owed by such individual to the United States,

"(2) are required by law to be, and are, deducted from the remuneration or other payment involved, including but not limited to, Federal employment taxes, and fines and forfeitures ordered by court-martial,

"(3) are properly withheld for Federal, State, or local income tax purposes, if the withholding of such amounts is authorized or required by law and if amounts withheld are not greater than would be the case if such individual claimed all dependents to which he was entitled (the withholding of additional amounts pursuant to section 3402(i) of the Internal Revenue Code of 1954 may be permitted only when such individual presents evidence of a tax obligation which supports the additional withholding),

"(4) are deducted as health insurance premiums,

"(5) are deducted as normal retirement contributions (not including amounts deducted for supplementary coverage), or

"(6) are deducted as normal life insurance premiums from salary or other remuneration for employment (not including amounts deducted for supplementary coverage).".

(e) CONSUMER PROVISIONS.—

(1) Subsection (b) of section 303 of the Consumer Credit Protection Act (15 U.S.C. 1673(b)) is amended—

(A) by inserting "(1)" immediately after "(b)",

(B) by redesignating clauses (1), (2), and (3) thereof as clauses (A), (B), and (C), respectively, and

(C) by adding at the end thereof the following new paragraph:

"(2) The maximum part of the aggregate disposable earnings of n individual for any workweek which is subject to garnishment to force any order for the support of any person shall not exceed—

"(A) where such individual is supporting his spouse or dependent child (other than a spouse or child with respect to whose support such order is used), 50 per centum of such individual's disposable earnings for that week; and

"(B) where such individual is not supporting such a spouse o dependent child described in clause (A), 60 per centum of suc individual's disposable earnings for that week;

except that, with respect to the disposable earnings of any individu for any workweek, the 50 per centum specified in clause (A) shall b deemed to be 55 per centum and the 60 per centum specified in claus (B) shall be deemed to be 65 per centum, if and to the extent that suc earnings are subject to garnishment to enforce a support order wit respect to a period which is prior to the twelve-week period which end with the beginning of such workweek.".

15 USC 1673.

(2) The provision of section 303(b) of the Consumer Credi Protection Act which is redesignated under paragraph (1) a clause (A) is amended by striking out all that follows "any order" and inserting in lieu thereof the following: "for the support o any person issued by a court of competent jurisdiction or i accordance with an administrative procedure, which is establishe by State law, which affords substantial due process, and which i subject to judicial review.".

(3) Section 303(c) of such Act is amended by inserting ", an no State (or officer or agency thereof)," immediately after "o any State".

15 USC 1675.

(4) Section 305 of such Act is amended by inserting "and (b) (2)" immediately after "section 303(a)" each place it appear therein.

Effective date.
15 USC 1673 note.

(5) The amendments made by this subsection shall take effect on the first day of the first calendar month which begins after the date of enactment of this Act.

SEC. 502. BONDING OF CERTAIN STATE OR LOCAL EMPLOYEES; HANDLING OF CASH RECEIPTS.

42 USC 654.

(a) IN GENERAL.—Section 454 of the Social Security Act i amended—

(1) by striking out "and" at the end of paragraph (12),

(2) by striking out the period at the end of paragraph (13) and inserting a semicolon in lieu thereof, and

(3) by adding at the end thereof the following new paragraphs:

"(14) comply with such bonding requirements, for employees who receive, disburse, handle, or have access to, cash, as the Secretary shall by regulations prescribe; and

Regulations.

"(15) maintain methods of administration which are designed to assure that persons responsible for handling cash receipts shall not participate in accounting or operating functions which would permit them to conceal in the accounting records the misuse of cash receipts (except that the Secretary shall by regulations provide for exceptions to this requirement in the case of sparsely populated areas where the hiring of unreasonable additional staff would otherwise be necessary).".

42 USC 654 note.

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on the first day of the first calendar month which begins after the date of enactment of this Act.

SEC. 503. INCENTIVE PAYMENTS TO STATES AND LOCALITIES.

(a) IN GENERAL.—

42 USC 658.
42 USC 657.

(1) Section 458(a) of the Social Security Act is amended by striking out "parent—" and all that follows and inserting in lieu thereof "parent an amount equal to 15 per centum of any amount collected and required to be distributed as provided in section 457 to reduce or repay assistance payments.".

(2) Section 458(b) of such Act is amended by striking out "paragraphs (1) and (2) of". 42 USC 658.

(b) Effective Date.—The amendments made by subsection (a) hall be applicable with respect to amounts collected on and after October 1, 1977. 42 USC 658 note.

SEC. 504. ANNUAL REPORT OF THE SECRETARY.

(a) Report.—Section 452(a)(10) of the Social Security Act is mended to read as follows: 42 USC 652.

"(10) not later than three months after the end of each fiscal year, beginning with the year 1977, submit to the Congress a full and complete report on all activities undertaken pursuant to the provisions of this part, which report shall include, but not be limited to, the following: Submittal to Congress.

"(A) total program costs and collections set forth in sufficient detail to show the cost to the States and the Federal Government, the distribution of collections to families, State and local governmental units, and the Federal Government; and an identification of the financial impact of the provisions of this part;

"(B) costs and staff associated with the Office of Child Support Enforcement;

"(C) the number of child support cases in each State during each quarter of the fiscal year last ending before the report is submitted and during each quarter of the preceding fiscal year (including the transitional period beginning July 1, 1976, and ending September 30, 1976, in the case of the first report to which this subparagraph applies), and the disposition of such cases;

"(D) the status of all State plans under this part as of the end of the fiscal year last ending before the report is submitted, together with an explanation of any problems which are delaying or preventing approval of State plans under this part;

"(E) data, by State, on the use of the Federal Parent Locator Service, and the number of locate requests submitted without the absent parent's social security account number;

"(F) the number of cases, by State, in which an applicant for or recipient of aid under a State plan approved under part A has refused to cooperate in identifying and locating the absent parent and the number of cases in which refusal so to cooperate is based on good cause (as determined in accordance with the standards referred to in section 402(a)(26)(B)(ii)); 42 USC 601. 42 USC 602.

"(G) data, by State, on the use of Federal courts and on use of the Internal Revenue Service for collections, the number of court orders on which collections were made, the number of paternity determinations made and the number of parents located, in sufficient detail to show the cost and benefits to the States and to the Federal Government; and

"(H) the major problems encountered which have delayed or prevented implementation of the provisions of this part during the fiscal year last ending prior to the submission of such report.".

42 USC 652 note.

(b) Effective Date.—The amendment made by subsection (a) shal be effective in the case of reports, submitted by the Secretary of Health Education, and Welfare, after 1976.

Submittal to Congress.
42 USC 652 note.
42 USC 651.

(c) Supplemental Report.—The Secretary of Health, Education and Welfare shall submit to the Congress not later than June 30, 1977 a special supplemental report, with respect to activities undertake pursuant to part D of title IV of the Social Security Act during th fiscal year ending June 30, 1976, and during the transitional perio beginning July 1, 1976, and ending September 30, 1976. Such repor shall, with respect to such transitional period, contain all the data and information specified in clauses (A) through (H) of section 452(a) (10) of such Act (as amended by subsection (a) of this section), and with respect to the fiscal year ending June 30, 1976, contain all such data and information which was not included in the report made by such Secretary to the Congress on June 30, 1976, pursuant to sectio 452(a)(10) of such Act, as in effect on such date.

42 USC 652.

SEC. 505. CERTAIN AFDC PAYMENTS.

42 USC 603.

For purposes of determining the amount payable to the State of Georgia under section 403(a) of the Social Security Act on account of expenditures made by such State as aid to families with dependent children under its State plan approved under part A of title IV of such Act during calendar quarters, beginning after June 30, 1975, and prior to January 1, 1977, there shall be included as an offset against such expenditures amounts which—

(1) were collected as child support by the State pursuant t a plan approved under part D of such title IV, and

(2) were retained by the State pursuant to, and in accordanc with the provisions of, section 457(a)(2) or section 457(b)(1) of such Act.

42 USC 657.

Intergovernmental Antirecession Assistance Act of 1977.
42 USC 6721 note.

TITLE VI—INTERGOVERNMENTAL ANTI-RECESSION ASSISTANCE

Sec. 601. This title may be cited as the "Intergovernmental Antirecession Assistance Act of 1977".

Sec. 602. (a) Subsection (b) of section 202 of the Public Works Employment Act of 1976 (42 U.S.C. 6722(b)) is amended to read as follows:

"(b) Authorization of Appropriations.—Subject to the provisions of subsections (c) and (d) of this section, there are authorized to be appropriated for each of the five succeeding calendar quarters (beginning with the calendar quarter which begins on July 1, 1977) for the purpose of payments under this title—

"(1) $125,000,000, plus

"(2) $30,000,000 multiplied by the number of whole one-tenth percentage points by which the rate of seasonally adjusted national unemployment for the most recent calendar quarter which ended three months before the beginning of such quarter exceeded 6 per centum.".

(b) Subsection (c) of section 202 of such Act is amended to read as follows:

"(B) The term 'territorial population' means the most recent population for each territory as determined by the Bureau of Census.

"Territorial population."

"(C) The provisions of sections 203(c)(4), 204, 205, 206, 207, 208, 209, 210, 211, 212, and 213 shall apply to the funds authorized under this section.

42 USC 6723-6733.

"(c) PAYMENTS TO LOCAL GOVERNMENTS.—The governments of the territories are authorized to make payments to local governments within their jurisdiction from sums received under this section as they deem appropriate.".

Approved May 23, 1977.

LEGISLATIVE HISTORY:

HOUSE REPORTS: No. 95-27 pt. I (Comm. on Ways and Means), and No. 95-27 pt. II (Comm. on Appropriations), and No. 95-263 (Comm. of Conference).

SENATE REPORT No. 95-66 (Comm. on Finance).

CONGRESSIONAL RECORD, Vol. 123 (1977):

Mar. 8, considered and passed House.

Apr. 19-22, 25-29, considered and passed Senate, amended.

May 16, House and Senate agreed to conference report and resolved amendment in disagreement.

WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS:

Vol. 13, No. 22: May 23, Presidential statement.

Note.—A listing of the bill number, law number, title, date of approval, U.S. Statutes citation, and price of each public law is published on a current basis in the Federal Register under "List of Public Laws" in the Reminders section. The text of laws is not published in the Federal Register.

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House Report 95-27-I

No material re social security in this report.

95TH CONGRESS } HOUSE OF REPRESENTATIVES { REPORT No.
1st Session } { 95-27 PART II

THE TAX REDUCTION AND SIMPLIFICATION ACT OF 1977

MARCH 1, 1977.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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Mr. MAHON, from the Committee on Appropriations submitted the following

REPORT

[To accompany H.R. 3477]

The Committee on Appropriations, to whom was referred the bill (H.R. 3477) to provide for a refund of 1976 individual income taxes and other payments, to reduce individual and business income taxes, and to provide tax simplification and reform, having considered the same, report thereon without amendment and without recommendation.

EXPLANATION OF COMMITTEE ACTION

H.R. 3477 was originally reported from the Committee on Ways and Means on February 24, 1977, and was sequentially referred to the Committee on Appropriations for consideration as provided in section 401(b) of Public Law 93-344 (The Congressional Budget Act of 1974).

Section 401(b) provides that when an authorizing committee reports a bill containing entitlement authority and the entitlement authority is in excess of the amount allocated under the budget resolution, the bill shall be referred to the Committee on Appropriations. The Appropriations Committee then has 15 legislative days in which to deal with the bill. The Committee's authority over the bill relates only to the cost provisions of the legislation and not to the legislative policy it contains. After 15 days the committee is automatically discharged from further consideration of the bill if no action has been taken.

H.R. 3477 was referred to the Committee on Appropriations because it proposes entitlement authority in several instances for the fiscal year 1977 for which no allocation had been made in the Second Concurrent Budget Resolution to the Committee on Ways and Means. Provision for this entitlement authority has now been made in the Third Concurrent Resolution on the Budget which passed the House on February 23, 1977. However, since this Resolution has not yet passed the Senate and the Conference Report has not been adopted, it is the existing Second Concurrent Resolution which governs the sequential referral mechanism of the Budget Act.

COMMITTEE RECOMMENDATION

The Committee is reporting the bill without amendment and without recommendation. This action is being taken in recognition of the mainly technical nature under which H.R. 3477 was referred to the Committee and the fact that such referral would have been unnecessary if the Third Concurrent Resolution on the Budget had been in place, as it is almost certain to be within the week.

The actual entitlement provisions of the tax bill before the Committee are those related to providing a $50 rebate for individuals whose tax liability is less than $50 (estimated to cost $1.3 billion) and for beneficiaries of various programs such as Social Security, Railroad Retirement, Supplemental Security Income, and Aid to Families With Dependent Children (estimated to cost $1.5 billion). Because these items all require appropriations, the committee will have the opportunity to take action on actually providing the funds for them at a later time in an appropriation measure.

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Calendar No. 55

95TH CONGRESS }
1st Session }

SENATE

{ REPORT
{ No. 95-66

TAX REDUCTION AND SIMPLIFICATION ACT OF 1977

REPORT

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ON

H.R. 3477

together with

ADDITIONAL, MINORITY AND SUPPLEMENTAL VIEWS

MARCH 28 (legislative day, FEBRUARY 21), 1977.—Ordered to be printed

U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON : 1977

Calendar No. 95

[illegible]

TAX REDUCTION AND SIMPLIFICATION

[illegible]

[illegible]

comments relevant to P.L. 95-30 contained herein.

95TH CONGRESS } HOUSE OF REPRESENTATIVES { REPORT
1st Session } { No. 95-263

TAX REDUCTION AND SIMPLIFICATION ACT OF 1977

MAY 6, 1977.—Ordered to be printed

Mr. ULLMAN, from the committee of conference, submitted the following

CONFERENCE REPORT

[To accompany H.R. 3477]

The committee of conference on the disagreeing votes of the two Houses on the amendments of the Senate to the bill (H.R. 3477) to provide for a refund of 1976 individual income taxes and other payments, to reduce individual and business income taxes, and to provide tax simplification and reform, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the Senate recede from its amendments numbered 13, 14, 15, 17, 33, 35, 44, 45, 46, 47, 48, 51, 69, 70, 75, 77, 79, and 83.

That the House recede from its disagreement to the amendments of the Senate numbered 1A, 2, 3, 6, 7, 8, 9, 10, 11, 12, 16, 18, 19, 21, 22, 24, 25, 26, 27, 28, 29, 30, 31, 32, 34, 36, 37, 39, 40, 41, 42, 43, 49, 50, 52, 53, 54, 55, 56, 57, 59, 60, 61, 62, 63, 64, and 66; and agree to the same.

Amendment numbered 1:

That the House recede from its disagreement to the amendment of the Senate numbered 1, and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the Senate amendment, insert the following:

TITLE I—REDUCTION AND SIMPLIFICATION OF INDIVIDUAL INCOME TAXES

Sec. 101. Change in tax rates and tax tables to reflect permanent increase in standard deduction.
Sec. 102. Change in definition of taxable income to reflect change in tax rates and tables.
Sec. 103. Extension of individual income tax reductions.
Sec. 104. Change in filing requirements.
Sec. 105. Withholding tax.
Sec. 106. Effective dates.

TITLE II—REDUCTION IN BUSINESS TAXES

Sec. 201. Extension of certain corporate income tax reductions.
Sec. 202. New jobs credit.

TITLE III—PROVISIONS RELATING TO EFFECTIVE DATES AND OTHER PROVISIONS OF THE TAX REFORM ACT OF 1976

Sec. 301. Effective date of changes in the exclusion for sick pay.
Sec. 302. Changes in treatment of income earned abroad by United States citizens living or residing abroad.
Sec. 303. Underpayments of estimated tax.
Sec. 304. Underwithholding.
Sec. 305. Interest on underpayments of tax.
Sec. 306. Use of residence as day care facility.
Sec. 307. State legislators' travel expenses away from home.
Sec. 308. Treatment of intangible drilling costs for purposes of the minimum tax.
Sec. 309. Transfers of partial interests in property for conservation purposes.

TITLE IV—MISCELLANEOUS PROVISIONS

Sec. 401. Authorization of additional appropriations for the work incentive program.
Sec. 402. Rapid amortization of child care facilities.
Sec. 403. Election of former retirement income credit provisions for 1976.
Sec. 404. Postponement of effective date of changes made by the Tax Reform Act of 1976 in the method of accounting for certain corporations engaged in farming.
Sec. 405. Withholding tax on certain gambling winnings.
Sec. 406. Termination of 1975 special payments to certain individuals.
Sec. 407. Payments to the governments of American Samoa, Guam, and the Virgin Islands.
Sec. 408. Withholding of county income tax on Federal employees.

TITLE V—CERTAIN SOCIAL SECURITY ACT AMENDMENTS

Sec. 501. Clarification of garnishment provisions.
Sec. 502. Bonding of certain State or local employees; handling of cash receipts.
Sec. 503. Incentive payments to States and localities.
Sec. 504. Annual report of the Secretary.
Sec. 505. Certain AFDC payments.

And the Senate agree to the same.

Amendment numbered 4:

That the House recede from its disagreement to the amendment of the Senate numbered 4, and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the Senate amendment insert the following:

INVESTMENT ANNUITIES

(Senate amendment numbered 83)

House bill.—No provision.

Senate amendment.—The Senate amendment postpones the effective date of Internal Revenue Service Revenue Ruling 77–85 (relating to investment annuity contracts) from March 9, 1977, to March 9, 1978.

Conference agreement.—The conference agreement omits the Senate amendment.

CERTAIN SOCIAL SECURITY ACT AMENDMENTS

(Senate amendment numbered 84)

House bill.—No provision.

Senate amendment.—The first section of the amendment clarifies the law which provides for the garnishment of Federal payment for purposes of child support and alimony. This section: (1) specifically authorizes the issuance of regulations by the three branches of Government charged with administering the garnishment law; (2) specifically includes the District of Columbia under the garnishment provisions; (3) provides specific conditions and procedures to be followed under the garnishment provisions relating to service of legal processes; (4) defines the terms used in the garnishment provisions; and (5) sets a limit of 50 percent on the amount of wages subject to garnishment for child support and alimony for a person supporting a second family and 60 percent for a person who is not (plus an additional 5 percent in each situation if there are outstanding arrearages under 12 weeks old).

The second section of the amendment: (1) requires bonding of all State and local employees, or employees of contractors used by agencies, who handle the collection of child support payments, and (2) provides that persons handling cash be separate from those in the accounting function.

The third section of the amendment sets at 15 percent the proportion of child support payments retained by the State in which the recipient family lives which will be paid as an incentive to the political subdivision within the State, or to another State, which makes the collections.

The fourth section of the amendment relates to the annual report on the child support program which must be submitted to the Congress by the Secretary of Health, Education and Welfare. The section: (1) lists the specific kinds of information to be included in the annual report; (2) requires that an annual report be submitted to the Congress within 3 months of the end of each fiscal year; and (3) requires a special supplemental report on fiscal year 1976 and the transitional quarter by June 30, 1977.

The fifth section: validates a letter of exception by the Department of Health, Education, and Welfare to Georgia dated January 22, 1976, permitting that State until the end of calendar year 1976 to work out a problem of interpretation concerning the treatment of child support collections for purposes of reimbursement.

Conference agreement.—The conference agreement follows the Senate amendment.

EXTENSION OF COUNTERCYCLICAL REVENUE SHARING

(Senate amendment numbered 85)

House bill.—No provision.

Senate amendment.—The Senate amendment extends and makes some minor technical revisions in the current countercyclical revenue sharing legislation which expires September 30, 1977. The ceiling on the aggregate authorization under current law occurred in April 1977 with a distribution of $60 million to eligible State and local governments. Accordingly, no more payments can be made under current law. Under the Senate amendment, up to $1 billion in additional funding is authorized for fiscal year 1977, and up to $2.25 billion is authorized for fiscal year 1978. The aggregate amount to be provided is amended to depend on tenths of unemployment percentages rather than half percentage points. Currently, each half percentage point by which the national unemployment rate exceeds 6 percent, generates $62.5 million.

The amendment provides that each tenth of a percentage point generate $30 million for allocation in addition to the basic $125 million. The amendment further provides that payments be made to Puerto Rico and the Virgin Islands on a formula basis. The amount to be distributed equals 1 percent of the national aggregate amount and is in addition to the national amount. Allocation between Puerto Rico and the Virgin Islands is based on their relative population size, as determined by the Bureau of the Census.

The Senate amendment updates the data to be used in the formula. Currently, the formula uses the unemployment rate in excess of 5.4 percent and the fiscal year 1976 revenue sharing entitlement payments. The amendment provides that more up to date entitlement payment data be utilized.

Conference agreement.—This amendment was reported in technical disagreement.

Al Ullman,
James A. Burke,
Dan Rostenkowski,
Charles Vanik,
Omar Burleson,
Barber B. Conable, Jr.,
John J. Duncan,
Managers on the Part of the House.
Russell Long,
Herman Talmadge,
Abraham Ribicoff,
Harry F. Byrd, Jr.,
Lloyd Bentsen,
Floyd K. Haskell,
Managers on the Part of the Senate.

○

Finder's Aid

P.L. 95-59 (91 Stat. 255) Approved June 30, 1977

Subject	SS Act Section	P.L. Section	H. Rep. 95-80	S. Rep. 95-298
Extends Period of Food Stamp Eligibility for SSI Recipients to 9/30/78	455(a)	3	--	1, 3, 5, 7, 9
Extension of Due Date for Child Care Study	2002(a)(9)(B)	5	--	2, 4, 11

II

Public Law 95-59
95th Congress

An Act

For the relief of Smith College, Northampton, Massachusetts, and for other purposes.

June 30, 1977
[H.R. 1404]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That the Secretary of the Treasury shall admit free of duty thirty-three carillon bells (including all accompanying parts and accessories) for the use of Smith College, Northampton, Massachusetts, such bells being provided by the Paccard Fonderie de Cloches, Annecy, France.

Smith College, Northampton, Mass.; Social Security Act. Amendments.

SEC. 2. If the liquidation of the entry for consumption of any article subject to the provisions of the first section of this Act has become final, such entry shall be reliquidated and the appropriate refund of duty shall be made.

FOOD STAMP ELIGIBILITY FOR SUPPLEMENTAL SECURITY INCOME RECIPIENTS

SEC. 3. Effective July 1, 1977, section 8 of Public Law 93-233 is amended by striking out "June 30, 1977" where it appears—

(1) in the matter preceding the colon in subsection (a)(1), and in the new sentence added by such subsection, and

(2) in subsections (a)(2), (b)(1), (b)(2), (b)(3), and (f),

and by inserting in lieu thereof in each instance "September 30, 1978".

7 USC 2012.
7 USC 612c note.
7 USC 1431 note.
7 USC 612c note.
7 USC 1382e note.

EXTENSION OF FEDERAL FUNDS FOR CHILD SUPPORT COLLECTION AND PATERNITY ESTABLISHMENT SERVICES PROVIDED FOR PERSONS NOT RECEIVING AID TO FAMILIES WITH DEPENDENT CHILDREN

SEC. 4. Section 455(a) of the Social Security Act is amended by striking out "June 30, 1977" in the matter following paragraph (2) and inserting in lieu thereof "September 30, 1978".

42 USC 655.

EXTENSION OF TIME FOR MAKING REPORT BY SECRETARY REGARDING CHILD DAY CARE SERVICES STANDARDS

SEC. 5. Section 2002(a)(9)(B) of the Social Security Act is mended by striking out "July 1, 1977" and inserting in lieu thereof "April 1, 1978".

42 USC 1397a.

DEFERRAL OF IMPLEMENTATION OF CERTAIN DECREASES IN MEDICA MATCHING FUNDS

42 USC 1396b note.
42 USC 1396b.
42 USC 1396 *et seq*

SEC. 6. Notwithstanding the provisions of subsection (*g*) of se tion 1903 of the Social Security Act, the amount payable to an State for the calendar quarters during the period commencin April 1, 1977, and ending September 30, 1977, on account of expend tures made under a State plan approved under title XIX of suc Act, shall not be decreased by reason of the application of th provisions of such subsection with respect to any period for whic such State plan was in operation prior to April 1, 1977.

Approved June 30, 1977

LEGISLATIVE HISTORY:

HOUSE REPORT No. 95-80 (Comm. on Ways and Means).
SENATE REPORT No. 95-290 (Comm. on Finance).
CONGRESSIONAL RECORD, Vol. 123 (1977):
Mar. 21, considered and passed House.
June 28, considered and passed Senate, amended.
June 30, House agreed to Senate amendment.

House Report 95-80

No material re social security in this report.

Calendar No. 276

95TH CONGRESS } SENATE { REPORT
1st Session } { No. 95–298

FOR THE RELIEF OF SMITH COLLEGE, NORTHAMPTON, MASS.

JUNE 24 (legislative day, MAY 18), 1977.—Ordered to be printed

Mr. LONG, from the Committee on Finance, submitted the following

REPORT

[To accompany H.R. 1404]

The Committee on Finance, to which was referred the bill (H.R. 1404) for the relief of Smith College, Northampton, Mass., having considered the same, reports favorably thereon, with an amendment and an amendment to the title, and recommends that the bill as amended do pass.

I. SUMMARY OF THE BILL

The bill, as passed by the House of Representatives, provides for the refund of duty paid by Smith College on the importation of bells needed to repair its carillon. The committee made no change in the House-passed provisions. The committee added to the bill, however, an amendment dealing with four matters requiring action before July 1, 1977, as follows:

Food stamp eligibility for SSI recipients.—The committee amendment will extend for 15 months (through September 30, 1978) temporary provisions of existing law which govern the eligibility for food stamps of persons who receive benefits under the supplemental security income (SSI) program. Under the existing temporary provisions which are continued by the committee amendment, SSI recipients in all States except California and Massachusetts are eligible for food stamps.

Funding of child support program for nonwelfare families.—State child support programs provide assistance to families in establishing the paternity of children and obtaining support for them from absent parents. These child support services are available to both welfare and nonwelfare families and Federal matching funds are now provided for the costs of serving both types of families. Effective July 1, 1977, however, current law would cease to provide Federal matching in the case of child support services for nonwelfare families. The committee amendment would continue Federal matching for such services to nonwelfare families for an additional 15 months—through the end of fiscal year 1978.

Extension of deadline for child care study.—Title XX of the Social Security Act requires the Secretary of Health, Education, and Welfare to report to the Congress on the appropriateness of child care standards mandated by that title and on his recommendations for any changes in those standards. The deadline for this report is July 1, 1977, under present law. The committee amendment to the bill would extend that deadline to April 1, 1977.

Barring of certain medicaid decreases.—A provision of the medicaid statute calls for a reduction in State medicaid matching funds in cases where the State does not conduct regular independent professional evaluations of patients in skilled nursing homes, intermediate care facilities, and mental hospitals. This provision has not previously been applied but the Department of Health, Education, and Welfare has announced its intention of reducing payments to States starting with the July–September 1977 quarter. The committee amendment would bar any such reductions prior to October 1, 1977, by which time it is anticipated that pending legislation related to this problem will have been considered.

II. General Explanation of the Bill

A. REFUND OF DUTY ON CARILLON BELLS FOR USE OF SMITH COLLEGE

Sections 1 and 2 of the bill

The purpose of the duty-free provision of H.R. 1404 is to enable Smith College to obtain a refund of the duties it has paid on the bells necessary to repair its carillon. The Paccard Bell Foundry in France supplied the original bells. Apparently, Paccard is the only source of the new bells since they must match those presently in place.

Under present law, the bells specified in the proposed bill would be classified under item 725.36 TSUS and dutiable at 7 percent ad valorem. The proposed legislation would permit the one-time entry of these items free of duty for use of Smith College, Northampton, Mass.

Section 1 directs the Secretary of the Treasury to admit free of duty 33 carillon bells (including accompanying parts and accessories) for the use of Smith College, Northampton, Mass.

Section 2 provides for a refund of duty if there has been a final liquidation of the entry of any article subject to the provisions of section 1.

The Treasury Department submitted a report with no objections.

The International Trade Commission submitted an information report.

No objections to sections 1 and 2 of this legislation have been received by the committee from any source.

B. FOOD STAMP ELIGIBILITY FOR RECIPIENTS OF SUPPLEMENTAL SECURITY INCOME (SSI)

Section 3 of the bill

Under existing law, supplemental security income (SSI) recipients are generally eligible for food stamp program benefits in all States except Massachusetts and California. In Massachusetts, the State receives a special Federal payment designed to compensate the State for paying an increased cash supplement to SSI recipients in lieu of food stamps. In California, although there is no longer a Federal payment, legislation was enacted in 1976 at the request of the State to continue the ineligibility of SSI recipients for food stamps because the State prefers to continue paying an increased cash supplement in lieu of food stamps.

The existing situation, however, is based on temporary legislation which expires as of June 30, 1977. After that date, the eligibility of SSI recipients in all States would be governed by legislation which was enacted in the 93d Congress but which has never been permitted to go into effect. Under that legislation, each individual's eligibility for food stamps would be determined by a complex process involving the measurement of his present income with and without food stamps against the income he would have had under the State welfare programs which were repealed at the end of 1973. It is generally believed that the provisions of the permanent law would be administratively unworkable. For this reason, the temporary provisions now in effect have been extended several times. General food stamp legislation passed by the Senate earlier this year would permanently resolve this issue. It appears that this legislation will not be enacted, however, before the June 30, 1977, expiration of the present temporary provisions. For this reason, the committee amendment simply extends the existing provisions for an additional period of time. The extension under the committee amendment would cover the 15 months starting July 1, 1977, and carrying through the end of fiscal year 1978 (September 30, 1978).

C. CHILD SUPPORT: FEDERAL FUNDS FOR SERVICES PROVIDED TO PERSONS NOT RECEIVING AFDC

Section 4 of the bill

On June 30, 1977, the authorization will expire for Federal matching funds for the costs of child support collection and paternity establishment services provided by States to individuals not receiving aid to families with dependent children.

The committee amendment would extend the authorization for Federal matching to October 1, 1978. The 15-month extension of the present law provision will assure that there will be no disruption in the operation of existing State programs.

The committee has been advised that in the last year, State child support agencies collected over $300 million for families with children who were not receiving aid to families with dependent children. Many of these families might have been forced to go on welfare if they had not had the benefit of these child support services. The amendment would promote the purpose of the child support legislation to assist families in receiving financial support from legally responsible parents and to reduce the need for welfare assistance.

D. EXTENSION OF REPORTING DATE FOR CHILD CARE APPROPRIATENESS STUDY

Section 5 of the bill

The Social Services Amendment of 1974 (Public Law 93–647) substantially revised the social services program under a new title (XX) of the Social Security Act. The 1974 legislation included a number of requirements for child care funded under the title XX program. It also directed the Secretary of Health, Education, and Welfare to submit an evaluation of the appropriateness of the child care requirements included in title XX including any recommended changes in those requirements. The statute specifies that this evaluation be sent to Congress during the first 6 months of 1977. The Secretary is authorized to modify the requirements by regulation no earlier than 90 days after the report has been submitted.

Although the law requires the report to be submitted by the end of June 1977, major ongoing studies of child care which the Department believes should be considered as a part of that report will not be completed by then. The question of what are the most appropriate Federal requirements for child care has been a source of continuing debate over the past several years. The Federal staffing standards which will be based on the Department's report may involve hundreds of millions of dollars in additional staffing costs. For this reason, the committee believes that the Department's evaluation report on this subject should be based on thorough study. The committee amendment would extend until April 1, 1978, the deadline for the submission of that report.

E. PROHIBITION AGAINST REDUCTION IN FEDERAL MEDICAID MATCHING PAYMENTS TO STATES, FOR QUARTER BEGINNING JULY, 1977, BECAUSE OF FAILURE TO COMPLY WITH STATUTORY REQUIREMENTS THAT NURSING HOME PATIENTS BE REGULARLY EVALUATED

Section 6 of the bill

Present law requires that States conduct regular independent professional evaluation of medicaid patients in skilled nursing and intermediate care facilities and in mental hospitals. Under the 1972 Social Security Amendments, Federal matching payments are to be automatically reduced by one-third for patients who are in skilled nursing homes or intermediate care facilities for more than 60 days. The reduced matching does not occur where a State demonstrates that it is satisfactorily undertaking the required regular independent review of all patients in all facilities.

The administration proposed and the House agreed in 1972 to an automatic reduction in matching regardless of whether proper patient review obtained. The Finance Committee modified the provision to continue full matching where the patient review was undertaken. The Senate and House conferees agreed with the Finance Committee position.

The independent review requirements were first enacted in 1967 because of numerous HEW Audit Agency and GAO reports indicating widespread inappropriate placement of medicaid patients in institutions. The 1972 amendments included the reduced matching provision because of the continued failure by many States to conduct the required patient review.

HEW will reduce Federal medicaid payments to 20 States for the July 1977 quarter by a total of $142 million for failure to comply with the independent professional review requirements during the first calendar quarter of this year. The essential problem is the severity of the reductions in terms of State budgetary difficulties balanced against the need to assure that Federal funds are expended only for patients receiving proper care in a proper setting.

Present law does not distinguish between significant and nominal noncompliance—the reductions are across the board. For example, in Kansas, only 13 out of 385 facilities were not reviewed in timely fashion; in Nebraska, only 5 out of 249 were missed; in Indiana, only 1 out of a total of 511 facilities; and in New Jersey, only 2 facilities out of 425 were not completed on time.

However, there was substantial noncompliance in other States. Ohio missed 408 out of 728 facilities; New York failed in 199 facilities out of 825; and 212 facilities out of 1,543 were not reviewed on time in California.

The committee expects to have before it in the near future legislation affecting medicaid that will provide the Senate with an opportunity to consider and develop permanent changes in current law relative to review requirements and reductions for noncompliance. To assure the time necessary to undertake statutory changes, the amendment approved by the committee prevents any reduction in Federal matching payments to States in the quarter beginning July 1 because of any prior noncompliance with the patient review requirements.

The committee understands that the Department of Health, Education, and Welfare has begun to make the July 1 grant awards to States. The grant awards made to at least five States have been reduced in accordance with section 1903(g). However, since the amendment approved by the committee would postpone any reduction in payments to States until October 1, 1977, the committee expects that HEW will make a supplemental grant award to restore funds to these States and to any other States whose grant awards might be reduced for noncompliance with 1903(g) either before or subsequent to enactment of this amendment.

III. Budgetary Impact of the Bill

In compliance with section 252(a) of the Legislative Reorganization Act, and sections 302(a) and 403 of the Congressional Budget Act, the following statements are made relative to the cost and revenue impact of the bill.

A. REVENUE IMPACT

The committee estimates that the cost of carrying out sections 1 and 2 will be a one-time revenue loss in customs revenue $2,250.

B. COST OF PROVISIONS RELATING TO SUPPLEMENTAL SECURITY INCOME, FOOD STAMP, SOCIAL SERVICES, CHILD SUPPORT, AND MEDICAL ASSISTANCE PROGRAMS

The following estimates are made by the committee after consultation with the Congressional Budget Office. No estimate pursuant to section 403 of the Congressional Budget Act has been received as of the time the bill is being reported.

The committee understands that the provisions of the bill relating to the supplemental security income, food stamp, social services, child support, and medical assistance programs would not change the present law estimates used by the Budget Committees for purposes of the congressional budget process since those estimates are based on a continuation of current policy in each of these programs and since the provisions in the bill simply extend the application of current policy which would otherwise be altered by the expiration of temporary legislation (in the case of the supplemental security income, social services, and child support programs) or by changes in administrative policy (in the case of the medical assistance program). The costs of these provisions are similarly included within the present law totals shown in the most recent budget allocation reports of this committee under section 302 of the Congressional Budget Act.

The provisions of the bill relating to these programs, therefore, are considered to have no budgetary impact for purposes of the congressional budget process. By comparison with present law, however, the provisions would have an impact as follows in fiscal year 1977 and 1978. (None of the provisions affect fiscal years after 1978.)

Supplemental security income provision.—If present permanent law were allowed to become effective, the cost of the food stamp program would be changed since some individuals in California and Massachusetts might become eligible for the program while many individuals in other States would lose eligibility. Administrative costs would be increased since a complex eligibility determination would be required in every case. No estimate is available of the net amount of the change in program costs which would occur if the present temporary provisions were not extended as proposed in this bill.

Social services program.—The committee estimates that the provision relating to the submission of a report by the Department of Health, Education, and Welfare on child care requirements involves no cost.

Child support program.—The committee estimates that the provisions related to Federal matching for child support services will have gross costs of about $7 million in fiscal year 1977 and $27 million in fiscal year 1978. Legislation enacted earlier this year (Public Law 95–19) included amendments to the child support program estimated to reduce Federal expenditures under that program by about $26 million in fiscal year 1978. Taken together and combined with the expected impact of the child support services in making it unnecessary in some cases for families to become dependent upon aid to families with dependent children, the committee believes that the provisions will result in no net increase in Federal spending.

Medicaid program.—Under existing law, the administration plans to institute a reduction in funding for certain States which would reduce Federal medicaid expenditures by an estimated $142 million. The committee bill will prevent any reduction from being applied during the July-September 1977 quarter. The provision has no cost impact in fiscal 1978.

IV. VOTE OF COMMITTEE IN REPORTING THE BILL

In compliance with section 133 of the Legislative Reorganization Act of 1946, the committee states that the bill, as amended, was ordered favorably reported by voice vote.

V. REGULATORY IMPACT OF THE BILL

In compliance with paragraph 5 of rule XXIX of the Standing Rules of the Senate, the committee states that the sections 1 and 2 of the bill will not regulate any individuals or businesses.

Sections 3 through 6 of the bill are extensions of existing law and thus involve no new regulatory impact.

VI. CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with subsection (4) of rule XXIX of the standing Rules of the Senate, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

PUBLIC LAW 93-233, AS AMENDED

* * * * * * *

ELIGIBILITY OF SUPPLEMENTAL SECURITY INCOME RECIPIENTS FOR FOOD STAMPS

SEC. 8. (a)(1) Section 3(e) of the Food Stamp Act of 1964 is amended effective only for the period ending [June 30, 1977] *September 30, 1978* to read as it did before amendment by Public Law 92-603 and Public Law 93-86, but with the addition of the following new sentence at the end thereof: "For the period ending [June 30, 1977] *September 30, 1978* no individual, who receives supplemental security income benefits under title XVI of the Social Security Act, State supplementary payments described in section 1616 of such Act, or payments of the type referred to in section 212(a) of Public Law 93-66, shall be considered to be a member of a household or an elderly person for purposes of this Act for any month during such period, if, for such month, such individual resides in a State which provides State supplementary payments (A) of the type described in section 1616(a) of the Social Security Act, and (B) the level of which has been found by the Secretary of Health, Education, and Welfare to have been specifically increased so as to include the bonus value of food stamps.".

(2) Section 3(b) of Public Law 93-86 shall not be effective for the period ending [June 30, 1977] *September 30, 1978*.

(b)(1) Section 4(c) of Public Law 93-86 shall not be effective for the period ending [June 30, 1977] *September 30, 1978*.

(2) The last sentence of section 416 of the Act of October 21, 1949 (as added by section 411(g) of Public Law 92-603) shall not be effective for the period ending [June 30, 1977] *September 30, 1978*.

(3) For the period ending [June 30, 1977] *September 30, 1978,* no individual who receives supplemental security income benefits under title XVI of the Social Security Act, State supplementary payments described in section 1616 of such Act, or payments of the type referred to in section 212(a) of Public Law 93-66, shall be considered to be a member of a household for any purpose of the food distribution program for families under section 32 of Public Law 74-320, section 416 of the Agricultural Act of 1949, or any other law, for any month during such period, if, for such month, such individual resides in a State which provides State supplementary payments (A) of the type described in section 1616(a) of the Social Security Act, and (B) the level of which has been found by the Secretary of Health, Education, and Welfare to have been specifically increased so as to include the bonus value of food stamps.

(c) For purposes of the last sentence of section 3(e) of the Food Stamp Act of 1964 (as amended by subsection (a) of this section) and subsections (b)(3) and (f) of this section, the level of State supplementary payment under section 1616(a) shall be found by the Secretary to have been specifically increased so as to include the bonus value of food stamps (1) only if, prior to October 1, 1973, the State has entered into an agreement with the Secretary or taken other positive steps which demonstrate its intention to provide supplementary payments under section 1616(a) at a level which is at least equal to the maximum level which can be determined under section 401(b)(1) of the Social Security Amendments of 1972 and which is such that the limitation on State fiscal liability under section 401 does result in a reduction in the amount which would otherwise be payable to the Secretary by the State, and (2) only with respect to such months as the State may, at its option, elect.

(d) Upon the request of the State of California the Secretary shall find, for purposes of the provisions specified in subsection (c) of this section, that the level of such State's supplementary payments of the type described in section 1616(a) of the Social Security Act has been specifically increased for any month after June 1976 so as to include the bonus value of food stamps if—

(1) the State law as in effect for such month specifically provides for increases in such payments on account of increases in the level of benefits payable under title XVI of the Social Security Act in a manner designed to assure that, whenever a cost-of-living increase in the level of benefits payable under such title XVI becomes effective for any month after June 1976, the amount of the State supplementary payment payable, for each month with respect to which such cost-of-living increase is effective, to any individual or to any individual with an eligible spouse, will be increased by such amount as is necessary to assure that—

(A) the aggregate of (i) the amount payable for such month to such individual, or to such individual with an eligible spouse, under such title XVI, and (ii) the amount payable for such month to such individual, or to such individual with an eligible spouse, under the State's supplementary payments program,

will exceed, by an amount which is not less than the monthly amount of such cost-of-living increase (plus the monthly amount of any previous cost-of-living increases in the level of benefits payable under title XVI of the Social Security Act which became effective for months after June 1976)—

(B) the aggregate of the amounts which would otherwise have been payable, to such individual (or to such individual with an eligible spouse), under such title XVI and under the State's supplementary payments program for such month under the law as in effect on June 1, 1976; and

(2) such month is (A) the month of July 1976, or (B) a month thereafter which is in a period of consecutive months the first of which is July 1976 and each of which is a month with respect to which the conditions of paragraph (1) are met.

As used in this subsection, the term "cost-of-living increase in the level of benefits payable under title XVI of the Social Security Act" means an increase in benefits payable under such title XVI by reason of the operation of section 1617 of such Act; except that the cost-of-living increase in the level of benefits payable under such title XVI which became effective for the month of July 1976 shall be deemed (for purposes of determining the amount of the required excess referred to in the matter following subparagraph (A) and preceding subparagraph (B) in paragraph (1)) to have provided an increase of $3.00 per month in the case of an individual without an eligible spouse and $4.50 per month in the case of an individual with an eligible spouse.

(e) Section 401(b)(1) of the Social Security Amendments of 1972 is amended by striking out everything after the word "exceed" and inserting in lieu thereof: "a payment level modification (as defined in paragraph (2) of this subsection) with respect to such plans."

(f) The amendment made by subsection (e) shall be effective only for the period ending [June 30, 1977] *September 30, 1978*, except that such amendment shall not during such period, be effective in any State which provides supplementary payments of the type described in section 1616(a) of the Social Security Act the level of which has been found by the Secretary to have been specifically increased so as to include the bonus value of food stamps.

* * * * * * *

SOCIAL SECURITY ACT

* * * * * * *

Title IV—Grants to States for Aid and Services to Needy Families With Children and for Child-Welfare Services

* * * * * * *

PART D—CHILD SUPPORT AND ESTABLISHMENT OF PATERNITY

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PAYMENTS TO STATES

Sec. 455. (a) From the sums appropriated therefor, the Secretary shall pay to each State for each quarter, beginning with the quarter commencing July 1, 1975, an amount—

(1) equal to 75 percent of the total amounts expended by such State during such quarter for the operation of the plan approved under section 454, and

(2) equal to 50 percent of the total amounts expended by such State during such quarter for the operation of a plan which meets the conditions of section 454 except as is provided by a waiver by the Secretary which is granted pursuant to specific authority set forth in the law;

except that no amount shall be paid to any State on account of furnishing child support collection or paternity determination services (other than the parent locator services) to individuals under section 454(6) during any period beginning after [June 30, 1977] *September 30, 1978.*

(b)(1) Prior to the beginning of each quarter, the Secretary shall estimate the amount to which a State will be entitled under subsection (a) for such quarter, such estimates to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsection, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (B) such other investigation as the Secretary may find necessary.

(2) The Secretary shall then pay, in such installments as he may determine, to the State the amount so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection.

(3) Upon the making of any estimate by the Secretary under this subsection, any appropriations available for payments under this section shall be deemed obligated.

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Title XX—Grants to States For Services

* * * * * * *

PAYMENTS TO STATES

Sec. 2002. (a)(1) * * *

(9)(A) No payment may be made under this section with respect to any expenditure in connection with the provision of any child day care service, unless—

(i) in the case of care provided in the child's home, the care meets standards established by the State which are reasonably in accord with recommended standards of national standard-setting organizations concerned with the home care of children, or

(ii) in the case of care provided outside the child's home, the care meets the Federal interagency day care requirements as approved by the Department of Health, Education, and Welfare

and the Office of Economic Opportunity on September 23, 1968; except that (I) subdivision III of such requirements with respect to educational services shall be recommended to the States and not required, and staffing standards for school-age children in day care centers may be revised by the Secretary, (II) the staffing standards imposed with respect to such care in the case of children under age 3 shall conform to regulations prescribed by the Secretary, (III) the staffing standards imposed with respect to such care in the case of children aged 10 to 14 shall require at least one adult for each 20 children, and in the case of school-aged children under age 10 shall require at least one adult for each 15 children, (IV) the State agency may waive the staffing standards otherwise applicable in the case of a day care center or group day care home in which not more than 20 per centum of the children in the facility (or, in the case of a day care center, not more than 5 children in the center) are children whose care is being paid for (wholly or in part) from funds made available to the State under this title, if such agency finds that it is not feasible to furnish day care for the children, whose care is so paid for, in a day care facility which complies with such staffing standards, and if the day care facility providing care for such children complies with applicable State standards, and (V) in determining whether applicable staffing standards are met in the case of day care provided in a family day care home, the number of children being cared for in such home shall include a child of the mother who is operating the home only if such child is under age 6,

except as provided in subparagraph (B).

(B) The Secretary shall submit to the President of the Senate and the Speaker of the House of Representatives, after December 31, 1976, and prior to [July 1, 1977] *April 1, 1978*, an evaluation of the appropriateness of the requirements imposed by subparagraph (A), together with any recommendations he may have for modification of those requirements. No earlier than ninety days after the submission of that report, the Secretary may, by regulation, make such modifications in the requirements imposed by subparagraph (A) as he determines are appropriate.

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Finder's Aid

P.L. 95-83 (91 Stat. 383) Approved August 1, 1977

bject	SS Act Section	P.L. Sec.	91 Stat.	H.Rep. 95-116	H.Rep. 95-118	S.Rep. 95-102	C.H.Rep. 95-500*	S.C.Rep. 95-349
uthorization or Appropria- ion of Mater- al & Child ealth & Crippled hildren's rograms	501	309	396	—	—	17, 20		20, 23
edicaid-- ompensation or Inspection f Institu- ions	1903	105	384	19 37-40	54-55	—		—

*Substantively identical with S.C. Report 95-349.

11

ublic Law 95–83
5th Congress

An Act

**amend the Public Health Service Act to extend through the fiscal year ending
September 30, 1978, the assistance programs for health services research; health
statistics; comprehensive public health services; hypertension programs;
migrant health; community health centers; medical libraries; cancer control
programs; the National Cancer Institute; heart, blood vessel, lung, and blood
disease prevention and control programs; the National Heart, Lung, and Blood
Institute; National Research Service Awards: population research and volun-
tary family planning programs; sudden infant death syndrome; hemophilia;
national health planning and development; and health resources develop-
ment; to amend the Community Mental Health Centers Act to extend it
through the fiscal year ending September 30, 1978; to extend the assistance
programs for home health services; and for other purposes.**

Aug. 1, 1977
[H.R. 4975]

*Be it enacted by the Senate and House of Representatives of the
nited States of America in Congress assembled,*

Health services programs. Extension. Health Planning and Health Services Research and Statistics Extension Act of 1977. 42 USC 201 note. 42 USC 300l–5.

ITLE I—HEALTH PLANNING AND HEALTH SERVICES RESEARCH AND STATISTICS EXTENSION

Sec. 101. This title may be cited as the "Health Planning and Health
rvices Research and Statistics Extension Act of 1977".

Sec. 102. (a) Section 1516(c)(1) of the Public Health Service Act
elating to authorizations for planning grants) is amended by strik-
g out "for the fiscal year ending June 30, 1977" and inserting in lieu
ereof "each for the fiscal years ending September 30, 1977, and
ptember 30, 1978".

(b) Section 1525(c) of such Act (relating to authorizations for
ate health planning and development agencies) is amended by
riking out "for the fiscal year ending June 30, 1977" and insert-
g in lieu thereof "each for the fiscal years ending September 30,
77, and September 30, 1978".

42 USC 300m–4.

(c) Section 1526(e) of such Act (relating to authorizations for
ants for rate regulation) is amended by striking out "for the fiscal
ar ending June 30, 1977" and inserting in lieu thereof "each for the
cal years ending September 30, 1977, and September 30, 1978".

42 USC 300m–5.

(d) Section 1534(d) of such Act (relating to authorizations for
nters for health planning) is amended by striking out "for the fiscal
ar ending June 30, 1977" and inserting in lieu thereof "each for the
cal years ending September 30, 1977, and September 30, 1978".

42 USC 300n–3.

Sec. 103. (a) Section 1613 of the Public Health Service Act
elating to authorizations for construction) is amended by striking
t "for the fiscal year ending June 30, 1977" and inserting in lieu
ereof "each for the fiscal years ending September 30, 1977, and Sep-
mber 30, 1978".

42 USC 300p–3.

(b) Section 1625(d) of such Act (relating to funds for project
ants) is amended by adding at the end the following new sentence:
n addition to the amounts made available for such grants under the
eceding sentence for the fiscal year ending September 30, 1978, there
e authorized to be appropriated $67,500,000 for such fiscal year for
ch grants.".

42 USC 300r.

(c) Section 1640(d) of such Act (relating to authorizations for area
alth services development) is amended by striking out "for the fis-
l year ending June 30, 1977" and inserting in lieu thereof "each for

42 USC 300t.

the fiscal years ending September 30, 1977, and September 30, 19

42 USC 242m.

Sec. 104. (a) Section 308(i)(1) of the Public Health Service
(relating to authorizations for the National Center for Health S
ices Research) is amended (1) by striking out "and" after "197
and (2) by inserting after "1976" the following: ", and $28,600
for the fiscal year ending September 30, 1978".

(b) Section 308(i)(2) of such Act (relating to authorizations
the National Center for Health Statistics) is amended (1) by st
ing out "and" after "1975,", and (2) by inserting after "1976"
following: ", and $33,600,000 for the fiscal year ending September
1978".

Payments to States.
42 USC 1396b.

Sec. 105. (a)(1) Section 1903(m)(2)(A) of the Social Secur
Act is amended to read as follows:

"(2)(A) Except as provided in subparagraphs (B) and (C),
payment shall be made under this title to a State with respect
expenditures incurred by it for payment (determined under a prep
capitation basis or under any other risk basis) for services provi
by any entity which is responsible for the provision of inpatient h
pital services and any other service described in paragraph (2), (
(4), (5), or (7) of section 1905(a) or for the provision of any thre
more of the services described in such paragraphs unless—

42 USC 1396d.

"(i) the Secretary (or the State as authorized by paragr
(3)) has determined that the entity is a health maintenance or
nization as defined in paragraph (1); and

"(ii) less than one-half of the membership of the entity cons
of individuals who (I) are insured for benefits under part B
title XVIII or for benefits under both parts A and B of such ti
or (II) are eligible to receive benefits under this title.".

(2) Section 1903(m)(2)(C) of such Act is amended by striking
"(A)(iii)" each place it occurs and inserting in lieu thereof "(A)(ii

Applicability.
42 USC 1396b note.
42 USC 1396.

(3) The amendments made by paragraphs (1) and (2) shall ap
with respect to payments under title XIX of the Social Security
to States for services provided—

(A) after October 8, 1976, under contracts under such t
entered into or renegotiated after such date, or

(B) after the expiration of the one-year period beginning
such date,

whichever occurs first.

42 USC 300e-8.

(b) Section 1309(a) of the Public Health Service Act is amend
by striking out "September 30, 1977" the second time it occurs
inserting in lieu thereof "September 30, 1979".

42 USC 300k-3.

Sec. 106. (a) The fourth sentence of section 1503(b)(1) of
Public Health Service Act is amended by inserting "establish
before "under section 1524".

42 USC 300*l*.

(b) The first sentence of section 1511(a) of such Act is amended
striking out "There" and inserting in lieu thereof "Except as provi
in section 1536, there".

42 USC 300*l*-1.

(c) Section 1512(b)(3)(B)(i) of such Act is amended by striki
out "subsections (e), (f), and (g)" and inserting in lieu thereof "s
sections (e), (f), (g), and (h)".

(d) Section 1512(c) of such Act is amended by striking out "ag
cies' health" and inserting in lieu thereof "agency's health".

42 USC 300*l*-2.

(e) The first sentence of section 1513(a) of such Act is amended
striking out "the provision" and inserting in lieu thereof "provisio

(f) The last sentence of section 1513(a) of such Act is amended
striking out "(g)" and inserting in lieu thereof "(h)".

ptember 30, 1977, and $1,930,000 for the fiscal year ending on ptember 30, 1978".

42 USC 2689b.

(b)(1) Section 203(d)(1) of such Act (relating to authorizations r initial operation) is amended (A) by striking out "and" after 976,", and (B) by striking out "for fiscal year 1977" and inserting lieu thereof the following: "for the fiscal year ending September 30, 77, and $38,890,000 for the fiscal year ending September 30, 1978".

(2) Section 203(d)(2) of such Act (relating to continuation grants) amended (A) by striking out "1977" and inserting in lieu thereof 978", and (B) by striking out "or the next fiscal year" and inserting lieu thereof "or the next two fiscal years".

42 USC 2689c.

(c) Section 204(c) of such Act (relating to authorizations for nsultation and education services) is amended (1) by striking out nd" after "1976,", and (2) by striking out "for fiscal year 1977" d inserting in lieu thereof the following: "for the fiscal year ending ptember 30, 1977, and $15,000,000 for the fiscal year ending Sep- nber 30, 1978".

42 USC 2689d.

(d) Section 205(c) of such Act (relating to authorizations for nversion grants) is amended (1) by striking out "and" after "1976,", d (2) by striking out "for fiscal year 1977" and inserting in lieu reof the following: "for the fiscal year ending September 30, 1977, d $23,000,000 for the fiscal year ending September 30, 1978".

42 USC 2689h.

(e) Section 213 of such Act (relating to authorizations for financial tress grants) is amended (1) by striking out "and" after "1976,", d (2) by striking out "for fiscal year 1977" and inserting in lieu reof the following: "for the fiscal year ending September 30, 1977, d $13,500,000 for the fiscal year ending September 30, 1978,".

42 USC 2689p.

(f) Section 228 of such Act (relating to authorizations for facili- s assistance) is amended (1) by striking out "and" after "1976,", d (2) by inserting after "1977," the following: "and $2,500,000 for fiscal year ending September 30, 1978,".

42 USC 2689q.

(g) Section 231(d) of such Act (relating to authorizations for rape evention and control) is amended (1) by striking out "and" after 976,", and (2) by striking out "for fiscal year 1977" and inserting lieu thereof the following: "for the fiscal year ending September 30, 77, and $7,880,000 for the fiscal year ending September 30, 1978".

42 USC 2689b.

(h) Section 203(e)(1)(A)(i) of such Act (relating to conversion ants) is amended by striking out "two grants" and inserting in lieu reof "three grants".

42 USC 2689e.

(i) The last sentence of section 206(d) of such Act (relating to neral provisions) is amended by striking out "ninetieth" and insert- g in lieu thereof "one hundred and twentieth".

42 USC 701.

SEC. 309. (a) Section 501 of the Social Security Act (relating to thorizations for maternal and child health and crippled children's vices) is amended (1) by striking out "and" after "1972,", and (2) striking out "and each fiscal year thereafter" and inserting in lieu reof the following: "and for each of the next four fiscal years, and 9,864,200 for the fiscal year ending September 30, 1978, and for each al year thereafter".

42 USC 1396b note.

(b) Section 249B of the Social Security Amendments of 1972 (relat- g to compensation under medicaid for nursing home inspectors) is nded by striking out "June 30, 1977" and inserting in lieu thereof ptember 30, 1980".

Home health services.
42 USC 1395x note.

SEC. 310. (a) Section 602(a)(5) of Public Law 94–63 (relati
authorizations for home health services) is amended by inserting
“1977” the following: “, and $8,000,000 for the fiscal year ending
tember 30, 1978,”.

(b) Section 602(b)(4) of such Public Law (relating to auth
zations for home health services training) is amended (1) by stri
out “and” after “1976,”, and (2) by inserting after “1977” the fol
ing: “, and $4,000,000 for the fiscal year ending September 30, 19

State plans.
42 USC 4573.

SEC. 311. (a)(1) Section 303(a) of the Comprehensive Alc
Abuse and Alcoholism Prevention, Treatment, and Rehabilitation
of 1970 (relating to State plans) is amended by adding after and b
paragraph (16) the following:

“Each State plan shall pertain to the twelve-month period of the S
fiscal year which commences in the calendar year in which the
is submitted and shall be submitted not later than July 31 of
calendar year.”.

Review procedures, establishment.

(2) Section 303(b) of such Act is amended by adding at the
the following: “A State plan submitted under subsection (a) may
contain provisions relating to drug abuse or mental health. The Se
tary, acting through the National Institute on Alcohol Abuse
Alcoholism, shall establish procedures by which the Institute
review each State plan submitted under subsection (a) and u
which it shall complete its review of each such plan not later t
September 15 of the calendar year in which the plan is submitte
not later than sixty days after the plan is received by the Instit
whichever is later.”.

21 USC 1176.

(3) The second sentence of section 409(e) of the Drug Abuse O
and Treatment Act of 1972 (relating to State plans) is amende
striking out “commencing October 1 of the calendar year” and ins
ing in lieu thereof “of the State fiscal year which commences in
calendar year”.

42 USC 4572.

(b)(1) The first sentence of section 302(a) of the Comprehen
Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehab
tation Act of 1970 (relating to allotments) is amended by striking
“shall be less than $200,000.” and inserting in lieu thereof the foll
ing: “shall, except as provided in paragraph (2), be less than
greater of (A) $200,000, or (B) the amount of such State’s allotm
for the fiscal year ending June 30, 1976, unless the amount approp
ated under section 301 for allotments for the fiscal year ending June
1976, was greater than the amount appropriated for the fiscal year
which the minimum allotment determination is being made , in wh
case the minimum allotment prescribed by this clause shall be
amount which bears the same ratio to the amount allotted for the fi
year ending June 30, 1976, as the amount appropriated for the fi
year for which the minimum allotment determination is being m
bears to the amount appropriated for the fiscal year ending June
1976.”.

(2) Section 302(a) of such Act is further amended by inserti
“(1)” after “(a)” and by adding at the end the following:

“(2) If the amount appropriated under section 301 for any fi
year is less than the amount required to make for such fiscal year
minimum allotment prescribed by paragraph (1) to each State with
approved State plan, the minimum allotment for such fiscal year
a State with an approved State plan shall be an amount which be
the same ratio to the minimum allotment prescribed by paragr

for such State as the amount appropriated under section 301 for
h fiscal year bears to the amount of appropriations required to
ke the minimum allotment, as so prescribed, to each State with an
proved State plan.”.

(c) Section 311(c)(2)(B)(i) of such Act (relating to review of
plications) is amended by striking out “his” and inserting in lieu
reof “its”.

42 USC 4577.

(d) The second sentence of section 202 of the Drug Abuse Office
d Treatment Act of 1972 (relating to the Director of the Office of
ug Abuse Policy) is amended by striking out “any other depart-
nt or agency of the United States” and inserting in lieu thereof
ny department or agency of the United States engaged in any drug
ffic prevention function (as defined in section 103)”.

21 USC 1112.

SEC. 312. Section 208(g) of the Public Health Service Act is
ended by (1) striking out “fifty” and inserting in lieu thereof
fty-five”, and (2) inserting after “National Institutes of Health”
following: “and not less than five shall be for the National Insti-
e on Alcohol Abuse and Alcoholism for individuals engaged in
earch on alcohol abuse and alcoholism”.

42 USC 210.

SEC. 313. Section 603(b) of Public Law 94–63 is amended by strik-
out “Not later than 2 years from the date of enactment of this
t” and inserting in lieu thereof “Not later than August 30, 1977,”.

42 USC 289k–2 note.

SEC. 314. The Secretary of Health, Education, and Welfare, in coop-
tion with appropriate professional entities and individuals, shall
thin two years of the date of the enactment of this section (1)
ablish model standards with respect to preventive health services in
mmunities, and (2) report such standards to the Congress. Such
ndards shall be developed to identify populations in need of preven-
e or protective health services and to maintain community oriented
eventive health programs.

Preventive health services, model standards, establishment and report to Congress.
42 USC 242b note.

SEC. 315. (a)(1) The Secretary of Health, Education, and Welfare
ereinafter in this section referred to as “Secretary”) shall arrange
r the conduct of a study or studies to determine opportunities, if any,
r broadened Federal program activities in areas of international
alth. Such study or studies shall consider biomedical and behavioral
search, health services research, health professions education, immu-
zation and public health activities, and other areas that might
prove our and other nations’ capacities to prevent, diagnose, control,
cure disease, and to organize and deliver effective and efficient health
rvices.

International health activities, study.
42 USC 242*l* note.

(2) An interim report on such study or studies shall be completed
later than October 1, 1977. A final report thereon shall be com-
eted no later than January 1, 1978. Both reports shall be submitted
the Secretary, the Committee on Human Resources of the Senate,
d the Committee on Interstate and Foreign Commerce of the House
Representatives.

Reports, submittal to Secretary and congressional committees.

(b)(1) The Secretary shall request the National Academy of Sci-
ces (hereinafter in this section referred to as “Academy”) to con-
ct such study or studies under an arrangement whereby the actual
penses incurred by the Academy directly related to the conduct of
ch study or studies will be paid by the Secretary. If the Academy is
illing to do so, the Secretary shall enter into such an arrangement
ith the Academy.

Arrangement with National Academy of Sciences.

(2) If the Academy is unwilling to conduct one or more of studies under such an arrangement, then the Secretary shall enter a similar arrangement with other appropriate nonprofit private gr or associations to conduct such study or studies and prepare and sub the reports thereon as provided in subsection (a)(2).

Approved August 1, 1977.

LEGISLATIVE HISTORY:

HOUSE REPORTS: No. 95–117, No. 95–116 accompanying H.R. 4974, and 95–118 accompanying H.R. 4976 (all from Comm. on Inter and Foreign Commerce) and No. 95–500 (Comm. of Conferen
SENATE REPORTS: No. 95–102 (Comm. on Human Resources) and No. 95–3 (Comm. of Conference).
CONGRESSIONAL RECORD, Vol. 123 (1977):
- Mar. 31, considered and passed House; H.R. 4974 and H.R. 4976 conside and passed House.
- May 4, considered and passed Senate, amended.
- May 11, House agreed to Senate amendment with an amendment.
- July 15, Senate agreed to conference report.
- July 20, House agreed to conference report.

○

95TH CONGRESS } HOUSE OF REPRESENTATIVES { REPORT
1st Session } { No. 95–116

HEALTH PLANNING AND HEALTH SERVICES RESEARCH AND STATISTICS EXTENSION ACT OF 1977

MARCH 26, 1977.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. STAGGERS, from the Committee on Interstate and Foreign Commerce, submitted the following

REPORT

[To accompany H.R. 4974]

The Committee on Interstate and Foreign Commerce, to whom was referred the bill (H.R. 4974) to amend the Public Health Service Act to authorize appropriations for fiscal year 1978 for health planning and related programs, having considered the same, report favorably thereon without amendment and recommend that the bill do pass.

SUMMARY OF LEGISLATION

H.R. 4972, the Health Planning and Health Services Research and Statistics Extension Act of 1977, extends for one year without substantive modification the legislative authorities for health planning and resources development programs authorized by titles XV and XVI of the Public Health Service Act and for health services research and health statistics programs authorized by sections 304–308 of the PHS Act. It would authorize appropriations for the title XV and XVI programs for 1978 at the same level at which they were authorized for 1977 (see Cost of Legislation), because the authorizations in title XV are based upon formulas related to the population served by the programs supported and because these are new programs in their initial implementation phase needing additional appropriations for new agencies and activities as well as sufficient appropriations to compensate for the effects of inflation on existing agencies and activities. The other programs would be authorized at a level which is 115 percent of 1977's appropriation.

Part A of title XV of the Public Health Service Act requires the creation of a National Council on Health Planning and Development specifies national health priorities, and requires the development of national guidelines for health planning.

Statistics to authorize appropriation in fiscal year 1978 of $31.74 million. This amount is 115 percent of the $27.6 million which was appropriated for the National Center for Health Statistics in fiscal year 1977 under this authority. The committee is aware that the National Center received some additional funds during fiscal year 1977 from other authorities and that the total budget for the National Center for fiscal year 1978 is more than the authorized $31.74 million. As a matter of consistency the Committee has nevertheless applied its policy of authorizing 115 percent of the 1977 appropriation in this case but does understand that additional appropriations may be sought in fiscal year 1978, as they were obtained in fiscal year 1977, for the National Center from other authorities.

Section 5 makes two technical amendments to the HMO authorities of title XIX of the Social Security Act and title XIII of the Public Health Service Act as they were amended by Public Law 94–460 in 1976. The first, contained in section 5(a), amends section 1903(m)(2)(A) of the Social Security Act to provide that (except as provided in existing subparagraphs (B) and (C)) no payment shall be made under title XIX to a State with respect to expenditures incurred by it for payment (determined under a prepaid capitation basis or under any other risk basis) for services provided by any entity responsible for the provision of inpatient hospital services and any of the other required services described in paragraphs (2), (3), (4), (5) or (7) of section 1905(a), or for the provision of any three or more of the services described in those paragraphs. The Secretary is, however, allowed to make such payments if he (or the State as authorized by existing 1903(m)(3)) has determined that the entity in question is a health maintenance organization as defined in existing section 1903(m)(1), and that less than half of the membership of the entity consists of individuals who are eligible for parts A and B of medicare or are recipients of Medicaid benefits.

The amendment further makes a conforming correction in a cross-reference in section 1903(m)(2)(C) and makes the effective date for the changes which it makes the same as the one which would have prevailed under Public Law 94–460.

These amendments correct technically deficient language in the original law to achieve the committee's original policy that medicaid payments should not be available to HMO's which have memberships made up of a majority of people who are recipients of benefits under medicare and/or for medicaid.

The second technical amendment in section 5(b) amends section 1309(a) of the Public Health Service Act to authorize appropriations of $50 million in fiscal year 1979. Section 1309(a), as amended by Public Law 94–460, erroneously first authorizes appropriation of $45 million in fiscal year 1977 and then $50 million in fiscal year 1978 with no authorization given for fiscal year 1979, since in the latter case 1977 was mistakenly written in place of 1979.

Section 6 contains 27 technical amendments to titles XV and XVI of the Public Health Service Act correction incorrect cross-references and misspelled words, adding omitted words and phrases, and conforming them to the new Federal fiscal year.

(16) The term "medically underserved population" means the population of an urban or rural area designated by the Secretary as an area with a shortage of health facilities or a population group designated by the Secretary as having a shortage of such facilities.

* * * * * * *

PART F—AREA HEALTH SERVICES DEVELOPMENT FUNDS

DEVELOPMENT GRANTS FOR AREA HEALTH SERVICES DEVELOPMENT FUNDS

SEC. 1640. (a) The Secretary shall make in each fiscal year a grant to each health system agency—

(1) with which there is in effect a designation agreement under section 1515(c),

(2) which has in effect an HSP and AIP reviewed by the Statewide Health Coordinating Council, and

(3) which, as determined under the review made under section 1535(c), is organized and operated in the manner prescribed by section 1512(b) and is performing its functions under section 1513 in a manner satisfactory to the Secretary,

to enable the agency to establish and maintain an Area Health Services Development Fund from which it may make grants and enter into contracts in accordance with section 1513(c)(3).

(b)(1) Except as provided in paragraph (2), the amount of any grant under subsection (a) shall be determined by the Secretary after taking into consideration the population of the health service area for which the health systems agency is designated, the average family income of the area, and the supply of health services in the area.

(2) The amount of any grant under subsection (a) to a health systems agency for any fiscal year may not exceed the product of $1 and the population of the health service area for which such agency is designated.

(c) No grant may be made under subsection (a) unless an application therefor has been submitted to, and approved by, the Secretary. Such an application shall be submitted in such form and manner and contain such information as the Secretary may require.

(d) For the purpose of making payments pursuant to grants under subsection (a), there are authorized to be appropriated $25,000,000 for the fiscal year ending June 30, 1975, $75,000,000 for the fiscal year ending June 30, 1976, and $120,000,000 [for the fiscal year ending June 30, 1977] *each for the fiscal years ending September 30, 1977, and September 30, 1978.*

* * * * * * *

SECTION 1903 OF THE SOCIAL SECURITY ACT

PAYMENT TO STATES

SEC. 1903. (a) * * *

* * * * * * *

(m)(1)(A) The term "health maintenance organization" means a legal entity which provides health services to individuals enrolled in such organization and which—

(i) provides to its enrollees who are eligible for benefits under this title the services and benefits described in paragraphs (1), (2), (3), (4)(C), and (5) of section 1905, and, to the extent required by section 1902(a)(13)(A)(ii) to be provided under a State plan for medical assistance, the services and benefits described in paragraph (7) of section 1905(a);

(ii) provides such services and benefits in the manner prescribed in section 1301(b) of the Public Health Service Act (except that, solely for purposes of this paragraph, the term "basic health services" and references thereto, when employed in such section, shall be deemed to refer to the services and benefits described in paragraphs (1), (2), (3), (4)(C), and (5) of section 1905(a), and, to the extent required by section 1902(a)(13)(A)(ii) to be provided under a State plan for medical assistance, the services and benefits described in paragraph (7) of section 1905(a)); and

(iii) is organized and operated in the manner prescribed by section 1301(c) of the Public Health Service Act (except that solely for purposes of this paragraph, the term "basic health services" and references thereto, when employed in such section shall be deemed to refer to the services and benefits described in section 1905(a) (1), (2), (3), (4)(C), and (5), and to the extent required by section 1902(a)(13)(A)(ii) to be provided under a State plan for medical assistance, the services and benefits described in paragraph (7) of section 1905(a)).

(B) The duties and functions of the Secretary, insofar as they involve making determinations as to whether an organization is a health maintenance organization within the meaning of subparagraph (A), shall be administered through the Assistant Secretary for Health and in the Office of the Assistant Secretary for Health, and the administration of such duties and functions shall be integrated with the administration of section 1312 (a) and (b) of the Public Health Service Act.

[(2)(A) Except as provided in subparagraphs (B) and (C), no payment shall be made under this title to a State with respect to expenditures incurred by it for payment for services provided by any entity—

[(i) which is responsible for the provision of—

[(I) inpatient hospital services and any other service described in paragraph (2), (3), (4), (5), or (7) of section 1905(a), or

[(II) any three or more of the services described in such paragraphs,

when payment for such services is determined under a prepaid capitation risk basis or under any other risk basis;

[(ii) which the Secretary (or the State as authorized by paragraph (3)) has not determined to be a health maintenance organization as defined in paragraph (1); and [(iii) more than one-half of the membership of which consists of individuals who are insured under parts A and B of title XVIII or recipients of benefits under this title.]

(2)(A) Except as provided in subparagraphs (B) and (C), no payment shall be made under this title to a State with respect to expenditures incurred by it for payment (determined under a prepaid capitation basis or under any other risk basis) for services provided by any entity which is responsible for the provision of inpatient hospital services and any other service described in paragraph (2), (3), (4), (5), or (7) of section 1905(a) or for the provision of any three or more of the services described in such paragraphs unless—

(i) the Secretary (or the State as authorized by paragraph (3)) has determined that the entity is a health maintenance organization as defined in paragraph (1); and

(ii) less than one-half of the membership of the entity consists of individuals who are insured under parts A and B of title XVIII or recipients of benefits under this title.

(B) Subparagraph (A) does not apply with respect to payments under this title to a State with respect to expenditures incurred by it for payment for services provided by an entity which—

(i)(I) received a grant of at least $100,000 in the fiscal year ending June 30, 1976, under section 319(d)(1)(A) or 330(d)(1) of the Public Health Service Act, and (II) for the period beginning July 1, 1976, and ending on the expiration of the period for which payments are to be made under this title has been the recipient of a grant under either such section; and

(II) provides to its enrollees, on a prepaid capitation risk basis or on any other risk basis, all of the services and benefits described in paragraphs (1), (2), (3), (4)(C), and (5) of section 1905(a) and, to the extent required by section 1902(a)(13)(A)(ii) to be provided under a State plan for medical assistance, the services and benefits described in paragraph (7) of such section; or

(ii) is a nonprofit primary health care entity located in a rural area (as defined by the Appalachian Regional Commission)—

(I) which received in the fiscal year ending June 30, 1976, at least $100,000 (by grant, subgrant, or subcontract) under the Appalachian Regional Development Act of 1965, and

(II) for the period beginning July 1, 1976, and ending on the expiration of the period for which payments are to be made under this title either has been the recipient of a grant, subgrant, or subcontract under such Act or has provided services under a contract (initially entered into during a year in which the entity was the recipient of such a grant, subgrant, or subcontract) with a State agency under this title on a prepaid capitation risk basis or on any other risk basis; or

(iii) which has contracted with the single State agency for the provision of services (but not including inpatient hospital services) to persons eligible under this title on a prepaid risk basis prior to 1970.

(C) Subparagraph (A)[(iii)](*ii*) shall not apply with respect to payments under this title to a State with respect to expenditures incurred by it for payment for services by an entity during the three-year period beginning on the date of enactment of this subsection or beginning on the date the entity enters into a contract with the State under this title for the provision of health services on a prepaid risk basis, whichever occurs later, but only if the entity demonstrates to the satisfaction of the Secretary by the submission of plans for each year of such three-year period that it is making continuous efforts and progress toward achieving compliance with subparagraph (A)[(iii)](*ii*).

(3) A State may, in the case of an entity which has submitted an application to the Secretary for determination that it is a health maintenance organization within the meaning of paragraph (1) and for which no such determination has been made within 90 days of the submission of the application, make a provisional determination for the purposes of this title that such entity is such a health maintenance organization. Such provisional determination shall remain in force until such time as the Secretary makes a determination regarding the entity's qualification under paragraph (1).

95TH CONGRESS
1st Session
HOUSE OF REPRESENTATIVES
REPORT
No. 95–118

HEALTH SERVICES EXTENSION ACT OF 1977

REPORT

BY THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

[To accompany H.R. 4976]

MARCH 26, 1977.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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95TH CONGRESS } HOUSE OF REPRESENTATIVES { REPORT
1st Session } { No. 95-118

HEALTH SERVICES EXTENSION ACT OF 1977

MARCH 26, 1977.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. STAGGERS, from the Committee on Interstate and Foreign Commerce, submitted the following

REPORT

[To accompany H.R. 4976]

The Committee on Interstate and Foreign Commerce, to whom was referred the bill (H.R. 4976) to amend the Public Health Service Act, the Community Mental Health Centers Act, title V of the Social Security Act, and the program of assistance for home health services to authorize appropriations for fiscal year 1978 for health services programs, and for other purposes, having considered the same, report favorably thereon with amendments and recommend that the bill as amended do pass.

Page 5, line 14, strike out "$62,922,250" and insert in lieu thereof "$67,838,000".

Page 5, line 10, insert "(1)" after "(c)"; redesignate clauses (1) and (2) in lines 11 and 12 as clauses (A) and (B), respectively; and after line 15 insert the following:

(2) Section 1004(b)(2) of such Act (relating to limitation on source of funds) is amended by adding immediately before the period the following: "or for the administration of this section".

Page 6, line 1, strike out "June 30," and insert in lieu thereof "fiscal year".

Page 6, line 2, before "Sep-" insert "ending".

Page 8, line 16, before "and" insert "the second time it occurs".

Page 13, line 15, strike out "such" and insert in lieu thereof "the Public Health Service".

Page 14, line 10, after "for" insert "the".

LEGISLATIVE BACKGROUND

Legislation to amend the Public Health Service Act, the Community Mental Health Centers Act, title V of the Social Security Act, and the program of assistance for home health services to authorize appropriations for fiscal year 1978 for health services programs, and for other purposes, H.R. 3598, was introduced on February 16, 1977, by Mr. Rogers, Chairman of the Subcommittee on Health and the Environment, and eleven members of the Subcommittee. Hearings were conducted on February 22, and 23, 1977. The bill was subsequently considered in open executive session by the Subcommittee on Health and the Environment, amended, reported, and reintroduced as a clean bill, H.R. 4976, on March 14, 1977 by Mr. Rogers and eleven members of the Subcommittee. H.R. 4976 was considered by the Interstate and Foreign Commerce Committee on March 17, 1977, amended, and ordered reported by unanimous voice vote.

Similar legislation has not yet passed the Senate.

SUMMARY OF LEGISLATION

The proposed legislation would extend the authorizations of appropriations for fiscal year 1978 at 115 percent of fiscal year 1977 appropriations of the legislative authorities for the following health service delivery programs: grants to the States for comprehensive health services, hypertension, migrant health centers, community health centers, family planning, sudden infant death syndrome, hemophilia treatment centers, and the provision of home health services. In addition, it would increase the authorization of appropriations level of title V of the Social Security Act (Maternal and Child Health and Crippled Children's Services) to a level reflecting 115 percent of the fiscal year 1977 appropriation and continue the authority for blood separation centers and training in the provision of home health services for fiscal year 1978.

H.R. 4976 also makes minor revisions in the authorities for migrant health centers, community health centers, hypertension programs, and community mental health centers. The revisions are as follows:

1. An amendment to section 319(h)(1) of the Public Health Service Act (relating to authorizations for migratory health planning and development grants and contracts) which would continue for fiscal year 1978 the 25 percent limitation on the amount of appropriations which may be made available for planning and development purposes in non-high impact areas.

2. An amendment to section 319(h)(2) of the PHS Act (relating to authorizations for operation of migrant health centers) which would continue for fiscal year 1978 the limitation on the amount of appropriations which may be made available to provide services to non-high impact areas.

3. An amendment to section 330(b)(3) of the PHS Act (relating to the definition of medically underserved populations for the purpose of planning, developing, and operating community health centers to serve such populations) which would require the Secretary of HEW to take into account, in designating medically underserved populations, unusual local conditions which are a barrier to access to or availability of personal health services.

4. An amendment to section 314(d)(7)(B) of the PHS Act (relating to purposes for which grants for hypertension programs may be authorized) which would authorize hypertension programs to provide ambulatory care services where appropriate.

5. An amendment to section 203(e)(1)(A)(i) of the Community Mental Health Centers Act (relating to continuation grants) which would have the effect of postponing until fiscal year 1979 the date by which community mental health centers funded prior to the date of enactment of the Health Revenue Sharing and Health Services Act of 1975 (Public Law 94–63) must offer the comprehensive services mandated by such Act in order to be eligible for continued support.

H.R. 4976 also contains a series of technical and minor substantive amendments to the Health Professions Educational Assistance Act of 1976 (Public Law 94–484); the Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, as amended by Public Law 94–371; the Drug Abuse Office and Treatment Act of 1972, as amended by Public Law 94–237; the Nurse Training Act of 1975 (Public Law 94–63); the Indian Health Care Improvement Act (Public Law 94–437); and the Social Security Amendments of 1972 (Public Law 92–603).

Cost of Legislation

As reported by the Committee, H.R. 4976 provides authorizations of appropriations for fiscal year 1978 in the amounts shown in the following table. With two exceptions, authorizations for blood separation centers and home health services training grants, the amounts proposed to be authorized for fiscal year 1978 reflect a 15 percent increase over actual fiscal year 1977 appropriations.

(c) There are authorized to be appropriated for payments under grants under subsection (a) $20,000,000 for fiscal year 1976, [and] $20,000,000 [for fiscal year 1977] *for the fiscal year ending September 30, 1977, and $22,000,000 for the fiscal year ending September 30, 1978.*

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PART B—FINANCIAL DISTRESS GRANTS

* * * * * * *

AUTHORIZATION OF APPROPRIATIONS

SEC. 213. There are authorized to be appropriated $15,000,000 for fiscal year 1976, [and] $15,000,000 [for fiscal year 1977] *for the fiscal year ending September 30, 1977, and $12,000,000 for the fiscal year ending September 30, 1978,* for payments under grants under section 211.

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PART D—RAPE PREVENTION AND CONTROL

RAPE PREVENTION AND CONTROL

SEC. 231. (a) * * *

* * * * * * *

(d) For the purpose of carrying out subsection (b), there are authorized to be appropriated $7,000,000 for fiscal year 1976, [and] $10,000,000 [for fiscal year 1977] *for the fiscal year ending Sepetmber 30, 1977, and $5,750,000 for the fiscal year ending September 30, 1978.*

* * * * * * *

SECTION 501 OF THE SOCIAL SECURITY ACT

TITLE V—MATERNAL AND CHILD HEALTH AND CRIPPLED CHILDREN'S SERVICES

* * * * * * *

AUTHORIZATION OF APPROPRIATIONS

SEC. 501. For the purpose of enabling each State to extend and improve (especially in rural areas and in areas suffering from severe economic distress), as far as practicable under the conditions in such State,

(1) services for reducing infant mortality and otherwise promoting the health of mothers and children; and

(2) services for locating, and for medical, surgical, corrective, and other services and care for and facilities for diagnosis, hospitalization, and aftercare for, children who are crippled or who are suffering from conditions leading to crippling,

there are authorized to be appropriated $250,000,000 for the fiscal year ending June 30, 1969, $275,000,000 for the fiscal year ending June 30, 1970, $300,000,000 for the fiscal year ending June 30, 1971,

$325,000,000 for the fiscal year ending June 30, 1972, [and] $350,000,000 for the fiscal year ending June 30, 1973, [and each fiscal year thereafter] *and for each of the next four fiscal years, and $399,864,200 for the fiscal year ending September 30, 1978, and for each fiscal year thereafter.*

SECTION 249B OF THE SOCIAL SECURITY AMENDMENTS OF 1972

PAYMENTS TO STATES UNDER MEDICAID FOR COMPENSATION OF INSPECTORS RESPONSIBLE FOR MAINTAINING COMPLIANCE WITH FEDERAL STANDARDS

SEC. 249B. Section 1903(a) of the Social Security Act, as amended by sections 207(a)(2) and 235(a) of this Act, is further amended, effective for the period beginning October 1, 1972, and ending [June 30, 1977] *September 30, 1980*, by redesignating paragraph (4) as paragraph (5), and by inserting after paragraph (3) the following new paragraph:

> "(4) an amount equal to 100 per centum of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) which are attributable to compensation or training of personnel (of the State agency or any other public agency) responsible for inspecting public or private institutions (or portions thereof) providing long-term care to recipients of medical assistance to determine whether such institutions comply with health or safety standards applicable to such institutions under this Act; plus".

SECTION 602 OF PUBLIC LAW 94-63

AN ACT to amend the the Public Health Service Act and related health laws to revise and extend the health revenue sharing program, the family planning programs, the community mental health centers program, the programs for migrant health centers and community health centers, the National Health Service Corps program, and the programs for assistance for nurse training, and for other purposes

* * * * * * *

TITLE VI—MISCELLANEOUS

HOME HEALTH SERVICES

SEC. 602. (a)(1) * * *

* * * * * * *

(5) There are authorized to be appropriated $8,000,000 for fiscal year 1976, $2,000,000 for the period July 1, 1976, through September 30, 1976, $8,000,000 for the fiscal year ending September 30, 1977, *and $3,450,000 for the fiscal year ending September 30, 1978, for payments under grants under this subsection.*

(b)(1) The Secretary of Health, Education, and Welfare may make grants to public and nonprofit private entities to assist them in demonstrating the training of professional and paraprofessional personnel to provide home health services (as defined in section 1861(m) of the Social Security Act).

(2) Applications for grants under this subsection shall be in such form and contain such information as the Secretary shall by regulations, prescribe.

(B) The provisions of section 225(f)(1) of the Public Health Service Act (as in effect on September 30, 1977) prescribing the financial obligation of a participant in the Public Health and National Health Service Corps Scholarship Program who fails to complete an active duty service obligation incurred under that Program shall apply to any individual who received a scholarship under such Program for any school year ending before September 30, 1977, irrespective of whether such individual received such a scholarship after that date.

[(C) Periods of internship or residency served before September 30, 1976, in a facility of the National Health Service Corps or other facility of the Public Health Service in accordance with an agreement entered into under section 225(b) of the Public Health Service Act (as in effect before that date) shall be creditable in satisfying a service obligation incurred under the Public Health and National Health Service Corps Scholarship Program as revised by this subsection.]

(C) If an individual received a scholarship under the Public Health and National Health Service Corps Scholarship Program for any school year ending before September 30, 1977, periods of internship or residency served by such individual in a facility of the National Health Service Corps or other facility of the Public Health Service shall be creditable in satisfying such individual's service obligation incurred under that Program for such scholarship or for any scholarship received under the National Health Service Corps Scholarship Program for any subsequent school year.

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Calendar No. 82

95th Congress } SENATE { Report
1st Session } { No. 95-102

HEALTH ASSISTANCE PROGRAMS EXTENSION ACT OF 1977

April 26 (legislative day, February 21), 1977.—Ordered to be printed

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Mr. Kennedy, from the Committee on Human Resources,
submitted the following

REPORT

[To accompany H.R. 4975]

The Committee on Human Resources, to which was referred the bill (H.R. 4975), to amend the Public Health Service Act to authorize appropriations for fiscal year 1978 for biomedical research and related programs, having considered the same, reports favorably thereon with an amendment in the nature of a substitute and an amendment to the title and recommends that the bill (as amended) do pass.

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I. SUMMARY OF LEGISLATION

As approved by the Committee, H.R. 4975 would—

(1) Extend through the fiscal year ending September 30, 1978 without major substantive modifications, the assistance programs under the Public Health Service Act for health services research; health statistics; comprehensive public health services; hypertension; migrant health; community health centers; medical libraries; cancer control programs; the National Cancer Institute; heart, blood vessel, lung, and blood disease prevention and control programs; the National Heart, Lung, and Blood Institute; National Research Service Awards; population research and voluntary family planning; sudden infant death syndrome; hemophilia; national health planning and development; and health resources development;

(2) Extend through the fiscal year ending September 30, 1978 without major substantive modifications the assistance programs under the Community Mental Health Centers Act;

(3) Extend through the fiscal year ending September 30, 1978 without substantive modifications the assistance programs for home health services under Public Law 94–63;

(4) Establish five supergrade positions for the National Institute on Alcohol Abuse and Alcoholism and increase the number of National Cancer Institute consultants from 100 to 200;

(5) Authorize the Secretary of Health, Education, and Welfare to develop minimum public health standards to maintain preventive health care programs;

(6) Amend the health professions educational assistance laws to clarify language and correct errors in dates and titles; assure equity for loans, scholarships, and payback provisions for medical students who had made commitments under previous legislation; insure that general pediatrics is considered primary care at Area Health Education Centers; assure that all graduates of schools accredited by the Liaison Committee on Medical Education are treated the same; and guarantee that for admission into the third year of a U.S. medical school, U.S. citizens who have graduated from two-year U.S. medical schools will be treated the same as U.S. citizens who have successfully completed 2 years of a foreign medical school;

(7) Authorize an additional $135 million in grants for public hospitals to eliminate or prevent imminent safety hazards or avoid noncompliance with State or voluntary licensure or accreditation standards; and

(8) Authorize the Secretary of Health, Education, and Welfare to arrange for studies of international health issues and opportunities.

II. HISTORY OF LEGISLATION

The legislation was introduced on February 22, 1977, by Senators Kennedy, Schweiker, Williams, Javits, Randolph, Pell, Hathaway, Riegle and Stafford and was referred to the Committee on Human Resources. On February 23, 1977, the Subcommittee on Health and Scientific Research held a hearing on the legislation. Testimony was received from the Department of Health, Education and Welfare which testified in support of the legislation. In addition, statements, which were generally supportive, were supplied for the record by the following organizations and individual:

AFL-CIO.
American Cancer Society.
American College of Cardiology.
American College of Chest Physicians.
American Dental Association.
American Hospital Association.
American Library Association.
American Lung Association.
American Medical Association.
American Nurses' Association.
American Occupational Therapy Association.
American Psychiatric Association.
Association of American Medical Colleges.
Candlelighters.
Citizens for the Treatment of High Blood Pressure, Inc.
Cystic Fibrosis Foundation.
Federation of American Societies for Experimental Biology.
Health Insurance Association of America.
Mental Health Association.
National Association of Community Health Centers, Inc.
National Association of Counties.
National Council of Community Mental Health Centers.
National Governors' Conference.
John H. Vetne.

The subcommittee considered the legislation in open markup on March 18, 1977, and ordered it reported to the full Committee. On March 31, 1977, companion legislation passed the House and was subsequently referred to the committee for consideration. On April 5, 1977, the committee considered the legislation in open markup and ordered it favorably reported to the Senate.

NATIONAL RESEARCH SERVICE AWARDS

The Federal Government has been sponsoring the training of biomedical researchers since 1930. By 1971, the National Institutes of Health (NIH), through their fellowship and training grant programs, supported 38 percent of the nation's full time graduate students in the medical sciences and 21 percent in all biomedical sciences.

The National Research Act of 1974, Public Law 93–348, amended the Public Health Service Act by repealing existing research training authorities and consolidating them in the "National Research Service Awards" (NRSA) authority of the act.

The first awards under NRSA authority were made in fiscal year 1975. Since then research training programs funded under the authorities in existence previous to the NRSA have been phased out. By fiscal year 1978, 75 percent of individuals at the predoctoral level supported by NIH will be under the NRSA authority; for those at the post-doctoral level, the proportion will be 90 percent. The table below shows the numbers of persons receiving training through NIH. The program is proceeding in an orderly manner, consistent with recommendations of the NAS.

NATIONAL INSTITUTES OF HEALTH

RESEARCH TRAINEES—INDIVIDUALS

	1974 actual[1]	1975 actual[1]	1976 actual	1977 estimate	1978 request
Old programs	9,975	8,729	5,706	3,345	1,475
Predoctoral	[2]5,475	[2]4,800	3,257	2,304	1,044
Postdoctoral	[2]4,500	[2]3,929	2,448	1,041	431
NRSA		3,420	3,949	6,780	7,497
Predoctoral		876	1,473	2,507	3,074
Postdoctoral		2,544	2,476	4,273	4,423
Total	9,975	12,149	9,654	10,125	8,972
Predoctoral	[2]5,475	[2]5,676	4,730	4,811	4,118
Postdoctoral	[2]4,500	[2]6,473	4,924	5,314	4,854

[1] Excludes trainees funded from 1973 restored funds.

[2] Determination of distribution between pre- and postdoctoral support in the old programs in 1974 and 1975 required approximations.

POPULATION RESEARCH AND VOLUNTARY FAMILY PLANNING PROGRAMS

Until the 1960's, public attitudes toward family planning were characterized by ignorance or silence. Medical family planning services were generally available only to those who could afford them through private physicians and clinics. There was no national focus on the field until the passage of the Social Security Amendments of 1967 (Public Law 90–248), which included the Child Health Act of 1967, the first Act to establish a special project grant authority for family planning services. In the same year, the Economic Opportunity Amendments of 1967 established family planning as a special emphasis program of the Office of Economic Opportunity.

The growing Federal commitment toward direct provision of family planning services was embodied in the establishment, in October, 1969, of the National Center for Family Planning Services in HEW's

Health Services and Mental Health Administration. The creation of the NCFPS, to administer the family planning funds appropriated under title V of the SSA, reaffirmed the traditional Federal position that family planning services should be made available to those who desire such services, but because of income or other circumstances, are denied access to such services.

In 1970, a major new Congressional initiative in the fields of both population research and family planning was launched. The result was enactment of S. 2108, the Family Planning Services and Population Research Act of 1970 (P.L. 91–572). The Act's intent was to greatly expand the availability of voluntary family planning services with priority on low-income individuals. The Family Planning Act of 1970 amended the PHS Act by adding to it a new title X. The new title X provided authority to the Secretary of HEW to award project grants and contracts to entities establishing and operating voluntary family planning projects (sec. 1001). It also authorized (sec. 1002) a limited formula grant program to support the planning, establishment, maintenance, coordination and evaluation of family planning services offered by State health authorities. It should be noted that funds have never been requested by HEW or appropriated for this formula grant program. Training related to individual and State projects in family planning was provided for in a specific authorization (sec. 1003). The grant and contract authority and authorizations for appropriations for research in family planning and population was enlarged, and new authority (sec. 1004) was provided for the development and distribution of informational and educational materials pertaining to family planning and population growth. Specific provisions were also included in the new title X to insure that participation in family activities would be completely voluntary (sec. 1007)—a principle consistently adhered to with regard to Federal support of family planning services—and that none of the funds appropriated under the title would support programs using abortion as a method of family planning (sec. 1008).

It is estimated there are almost 6 million low-income individuals wishing family planning services but unable to obtain them because of economic reasons sometimes compounded by the inaccessibility of such services. There are probably another 3.5 million individuals with an income slightly over the defined poverty level for whom the cost of family planning services acts as a deterrent to the utilization of such services. Teenage pregnancy has become a significant health and social concern with one million teenagers between the ages of 15 and 19 becoming pregnant each year and 30,000 teenagers younger than 15 becoming pregnant each year. The appropriation of $130 million, an increase of $22.5 million over the fiscal year 1977 appropriation, would permit the expansion of family planning services programs to reach an additional 600,000 women over the 3,000,000 currently reached with title X funding support.

The committee bill authorizes the appropriation of $5 million for grants and contracts for training individuals representing all elements of the family planning clinic staff, with special attention being given to regional and local staff priorities in the establishment of training programs. Among the key personnel trained under this authority are family planning nurse practitioners, who have proven to be an invaluable asset in the provision of family planning services, as well as outreach workers who have been instrumental in making individuals in remote areas aware of the availability of these services. These individuals are essential if established family planning programs are to succeed in their efforts to expand their services to surrounding areas with limited health care resources. The modest increase of $2,000,000, over the fiscal year 1977 appropriation of $3 million, for training programs will help increase efforts to train these important family planning workers.

The committee bill authorizes the appropriation of $70 million for research in the biomedical, contraceptive development, behavioral, and program implementation fields related to family planning and population.

Appropriation of $70 million for fiscal year 1978, an increase of approximately $16 million over the amount appropriated in fiscal year 1977, will permit a modest expansion in population research, after the inflation factor is taken into consideration. Few medical research efforts promise the social and economic returns which can be obtained through investments in population research; the less effective our contraceptive technology is, the higher the costs of family planning services will be.

The committee bill authorizes the appropriation of $2.5 million for information and education programs. In fiscal year 1977, only $600,000 was appropriated for this purpose. Planned Parenthood reports that at least one million young women below age 20 become pregnant each year, and the vast majority of these pregnancies are not planned. In addition, that organization reports that less than 40 percent of single teenage women know the period of time during which they are likely to become pregnant, and 30 percent of teenage women are unaware of where they can obtain family planning services. These figures make compelling arguments for an expanded informational and educational program that can reach these young people.

The $2.5 million recommended for this purpose would enable HEW to initiate and expand efforts to provide educational and informational materials to these young people.

Sudden Infant Death Syndrome

Some 7,000 infants die each year in this country of Sudden Infant Death Syndrome, a mysterious disease which strikes quickly and which cannot be prevented or cured.

The Committee has been deeply concerned with both the need for support of research into this disease, and the need for public and professional education information and counseling about it. As a result of this concern, the Congress enacted the Sudden Infant Death Syndrome Act in 1974. Through 31 centers located around the country, this program provides education and training to the personnel—social workers, police, doctors, etc.—who come into contact with the families who have lost infants to SIDS; encourages the coordination and development of community resources for dealing with SIDS cases; and supports the development of informational and educational materials about the disease and its effects on families.

In fiscal year 1976 31 SIDS projects were supported in 27 States. The number of infant deaths attributed to the Sudden Infant Death Syndrome in the area served by these projects is estimated at 4,550 per year, well over half the annual estimated total of 6,500 SIDS deaths in the United States.

Twenty-two of these projects have been operational since July 1, 1975. In their first annual report these projects showed: 1,308 families served; 1,362 autopsies for suspected cases of SIDS; and 1,596 hours of educational programs for SIDS.

The committee bill authorizes the appropriation of $3 million for fiscal year 1978 which will enable the program to expand its reach to a greater proportion of those families which lose children and to establish programs in some of the more populous of the 23 States in which no programs now exist.

Hemophilia Programs

Special authority for hemophilia programs was provided under Public Law 94–63 to provide Federal assistance to establish comprehensive hemophilia diagnostic and treatment centers, and to develop and expand, within existing facilities, blood-separation centers. In enacting this legislation, Congress noted that, while there were 67 existing hemophilia treatment centers in 27 States, there was a need for such facilities in areas which had no or limited diagnostic and treatment facilities. In addition, support for blood-separation centers was recognized as necessary in order to make optimal and more efficient use of blood components and to encourage the blood banking community to make components more readily available.

There are currently 17 hemophilia diagnostic and treatment centers which are supported through this program. These centers serve an estimated 2,300 people.

Health Planning and Resources Development

The National Health Planning and Resources Development Act, Public Law 93–641, was passed in January, 1975, in response to substantial evidence that (1) there was insufficient control over rapidly rising health care expenditures; (2) existing health resources and services were not effectively distributed; and (3) there were inadequate methods for ensuring that new technology would be available on an equitable basis, as required for quality health care without unnecessary duplication of services.

In passing Public Law 93–641 Congress concluded that there was a pressing need to restructure and strengthen State and local health planning, resource development, and regulatory efforts previously carried out under the comprehensive health planning, Hill-Burton, and regional medical programs. It also was evident that the development of a national planning policy which would guide resource allocation throughout the nation was required.

Considerable progress has been made in implementing Public Law 93–641 to date. The two-tiered structure of State and local health planning agencies is now largely in place. Health systems agencies (HSAs) have been designated and funded in 200 of the 205 heath service areas that were established in September 1975. State health planning and development agencies (SHPDA's) have been designated in 52 of the 56 States; and 33 of those also have established their Statewide Health Coordinating Councils (SHCC's).

Further reflection of progress is seen in the staffing and governance of these agencies. By late 1976 the aggregate staff of the HSA's exceeded 2,000 professional and support personnel, and SHPDA staffs totalled over 900.

It is estimated that over 8,000 consumers and providers presently are serving on HSA governing bodies. These governing bodies, and the public officials, providers, and consumers serving on them, are responsible for the governance of HSAs, a critical role. One significant feature of the new program, which distinguishes it from the previous comprehensive health planning program, is the high level of interest and involvement of public officials, especially local elected officials.

Most HSAs during their first year of operation devoted a significant fraction of their time and effort to organizational development, for example, establishing their governing boards, recruiting staff. Now they are increasingly devoting attention to the development of their long-range Health Systems Plans (HSP's) and Annual Implementation Plans (AIP's).

While it is anticipated that few HSA's will achieve full designation by the end of the 1977 fiscal year, most of the HSAs will be fully designated sometime before the end of the 1978 fiscal year. The increased funding levels made available by Congress for HSA's in fiscal year 1977 should permit them to increase their staff and other capabilities, which in turn should lead to an acceleration in plan development and better enable them to assume the expanded responsibilities that will be required of them once accorded full designation.

COMMUNITY MENTAL HEALTH CENTERS

In February 1963, President Kennedy sent Congress a special message calling for "a bold new approach" to mental illness and mental retardation. In October 1963 Congress passed the community mental health centers program, authorizing Federal grants for construction of community mental health centers. Federal support for initial staffing was authorized in 1965 by Public Law 89–105, providing assistance on a declining basis over a 51-month period. The CMHC Act was expanded to include services for alcoholism and narcotics abusers with enactment of Public Law 90–574 in 1968. In 1970, Public Law 91–211 extended the support period for Federal staffing grants to 8 years, authorized a higher percentage of funds for construction and staffing in poverty areas, and established grant support for specialized children's services. Most recently, Public Law 94–63, enacted in 1975, required all centers to provide designated essential services as well as certain specialized services to children, the elderly, alcoholics, and drug dependent persons. It also created the National Center for the Prevention and Control of Rape, which conducts research into the legal, social and medical aspects of rape.

Presently, 650 centers have been funded of which 347, or 53 percent, are in urban and rural poverty areas. To achieve the goal of total U.S. coverage, it is estimated that an additional 850 centers will be needed.

Operating centers total 547, making services available to 82 million people, or 38 percent of the Nation's population. When the 650 funded Centers are fully operational services will be available to over 93 million persons. In 1975, over 1,600,000 persons received direct services, an increase of 312 percent over 1970. It is estimated that in 1977 over two million persons will receive direct services in CMHC's.

The more severe mental disorders, depressive disorders, schizophrenia, along with alcoholism and drug abuse, comprise nearly half the admissions to centers, 23 percent of all admissions are under age 18, with 42 percent under age 24.

CMHC's are located in all States, in the inner city districts of the largest metropolitan areas, in urban areas, and in the most rural areas of the country. Half are operated by private, nonprofit organizations and half are organized under State, county or municipal government. Most Centers (92 percent) represent the collaborative programming of two or more affiliating agencies.

Nationally, the support of all operating CMHC's is made up of 38 percent State and local governmental funds, 30 percent receipts for direct services, and 30 percent Federal CMHC grants. For every dollar of Federal CMHC operations support, $2.70 in non-Federal funds is used.

HOME HEALTH SERVICES

Originally authorized by Public Law 94–63, the home health services program provides grants to meet the initial costs of establishing and operating home health agencies and expanding the services available through existing agencies. Grants are made based on the relative needs by States for home health services with preference given to areas within a State where a high percentage of the population to be served is composed of individuals who are elderly, medically indigent, or both.

This program expands the capability to provide home health service to persons who are entitled to such services under titles XVII, XIX, and XX of the Social Security Act but are unable to receive such care because there are either no qualified providers of home health services or the capacity of the existing home health agency is limited. The most recent social security data indicate that the median number of visits provided to 100 medicare eligibles was 30 home health visits. It is generally accepted that increased utilization of home health services serves as a deterrent to institutionalization for the elderly, ill and handicapped and also provides for a more efficient use of medical care expeditures. Support is also available to public and nonprofit private entities to demonstrate the training of professional and paraprofessionals persons to administer and provide home health services.

It is intended that projects be provided initial funding with a view toward their becoming independent of Federal support.

During fiscal year 1976, 56 grants were awarded serving 15,000 persons for the expansion of services and 16 for the development of new agencies. It is anticipated that 40 additional projects will be funded in fiscal year 1977 (20 new and 20 expansion). During the period of the one-year extension of this authorization of this authority, it is projected that 40 home health projects will be funded (20 new and 20 expanded) bringing the total to 136 grants over the three-year period.

TITLE V—GRANTS FOR HEALTH PROFESSIONS SCHOOLS

* * * * * * *

Grant Requirements

SEC. 502 (*a*). [Effective] *Except as provided in subsection* (*b*), *effective* with respect to fiscal years beginning after September 30, 1977, part E of Title VII is amended (1) by striking out sections 771, 772, 773, and 774, and (2) by adding after 770 the following new section:

* * * * * * *

(b) Section 771(b)(3) as amended by this Act shall take effect on the date of enactment of this Act.

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95th Congress } HOUSE OF REPRESENTATIVES { Report
1st Session } { No. 95-500

AMENDING THE PUBLIC HEALTH SERVICE ACT

July 14, 1977.—Ordered to be printed

Mr. Staggers, from the committee of conference,
submitted the following

CONFERENCE REPORT

[To accompany H.R. 4975]

The committee of conference on the disagreeing votes of the two Houses on the amendment of the House to the amendment of the Senate to the text of the bill (H.R. 4975) to amend the Public Health Service Act to extend through the fiscal year ending September 30, 1978, the assistance programs for health services research; health statistics; comprehensive public health services; hypertension programs; migrant health; community health centers; medical libraries; cancer control programs; the National Cancer Institute; heart, blood vessel, lung, and blood disease prevention and control programs; the National Heart, Lung, and Blood Institute; National Research Service Awards; population research and voluntary family planning programs; sudden infant death syndrome; hemophilia; national health planning and development; and health resources development; to amend the Community Mental Health Centers Act to extend it through the fiscal year ending September 30, 1978; to extend the assistance programs for home health services; and for other purposes, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the Senate recede from its disagreement to the amendment of the House and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the House amendment insert the following:

TITLE I—HEALTH PLANNING AND HEALTH SERVICES RESEARCH AND STATISTICS EXTENSION

Sec. 101. This title may be cited as the "Health Planning and Health Services Research and Statistics Extension Act of 1977".

Sec. 102. (a) Section 1516(c)(1) of the Public Health Service Act (relating to authorizations for planning grants) is amended by striking out "for the fiscal year ending June 30, 1977" and inserting in lieu thereof "each for the fiscal years ending September 30, 1977, and September 30, 1978".

Material is substantially identical with Senate Conference Report 95-349.

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

mum flexibility in determining what may be the most appropriate form for public health service program standards. The conferees are aware of the recent efforts of the Association of State and Territorial Health Officials, the National Association of County Health Officials, the United States Conference of City Health Officers, and the American Public Health Association, with staff support from the Center for Disease Control, to develop such standards on a voluntary, collaborative basis. The conferees anticipate that the Secretary will rely on the experience and advice of these groups, and support their continued efforts as a basis for both the form and content of public health program standards development required in this section.

STUDIES OF INTERNATIONAL HEALTH ISSUES AND OPPORTUNITIES

The Senate amendment contained a provision not included in the House amendment which directed the Secretary of HEW to arrange for the conduct of a study or studies to determine opportunities, if any, for broadened Federal program activities in areas of international health.

The conference substitute conforms to the Senate amendment.

Harley O. Staggers,
Paul Rogers,
David Satterfield,
Tim Lee Carter,
James T. Broyhill,
Managers on the part of the House.
Edward M. Kennedy,
Harrison A. Williams, Jr.,
Claiborne Pell,
Gaylord Nelson,
Alan Cranston,
William D. Hathaway,
Jacob Javits,
Richard S. Schweiker,
John H. Chafee,
Managers on the part of the Senate.

○

95th Congress 1st Session } SENATE { Report No. 95-349

AMENDING THE PUBLIC HEALTH SERVICE ACT

July 14 (legislative day, May 18), 1977.—Ordered to be printed

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Mr. Kennedy, from the committee of conference, submitted the following

CONFERENCE REPORT

[To accompany H.R. 4975]

The committee of conference on the disagreeing votes of the two Houses on the amendment of the House to the amendment of the Senate to the text of the bill (H.R. 4975) to amend the Public Health Service Act to extend through the fiscal year ending September 30, 1978, the assistance programs for health services research; health statistics; comprehensive public health services; hypertension programs; migrant health; community health centers; medical libraries; cancer control programs; the National Cancer Institute; heart, blood vessel, lung, and blood disease prevention and control programs; the National Heart, Lung, and Blood Institute; National Research Service Awards; population research and voluntary family planning programs; sudden infant death syndrome; hemophilia; national health planning and development; and health resources development; to amend the Community Mental Health Centers Act to extend it through the fiscal year ending September 30, 1978; to extend the assistance programs for home health services; and for other purposes, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the Senate recede from its disagreement to the amendment of the House and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the House amendment insert the following:

TITLE I—HEALTH PLANNING AND HEALTH SERVICES RESEARCH AND STATISTICS EXTENSION

Sec. 101. This title may be cited as the "Health Planning and Health Services Research and Statistics Extension Act of 1977".

Sec. 102. (a) Section 1516(c)(1) of the Public Health Service Act (relating to authorizations for planning grants) is amended by striking out "for the fiscal year ending June 30, 1977" and inserting in lieu thereof "each for the fiscal years ending September 30, 1977, and September 30, 1978".

JOINT EXPLANATORY STATEMENT OF THE COMMITTEE OF CONFERENCE

The managers on the part of the House and the Senate at the conference on the disagreeing votes of the two Houses on the amendment of the House to the amendment of the Senate to the bill (H.R. 4975) to amend the Public Health Service Act to extend through the fiscal year ending September 30, 1978, the assistance programs for health services research; health statistics; comprehensive public health services; hypertension programs; migrant health; community health centers; medical libraries; cancer control programs; the National Cancer Institution; heart, blood vessel, lung, and blood disease prevention and control programs; the National Heart, Lung, and Blood Institute; National Research Service Awards; population research and voluntary family planning programs; sudden infant death syndrome; hemophilia; national health planning and development; and health resources development; to amend the Community Mental Health Centers Act to extend it through the fiscal year ending September 30, 1978; to extend the assistance programs for home health services; and for other purposes, submit the following joint statement to the House and the Senate in explanation of the effect of the action agreed upon by the managers and recommended in the accompanying conference report:

The House passed H.R. 4974, H.R. 4975, and H.R. 4976, which extended various health programs for fiscal year 1978. The Senate amendment to the text of the bill struck out all after the enacting clause of H.R. 4975 and inserted a substitute text which extended the programs extended by H.R. 4974, H.R. 4975, and H.R. 4976. The House amendment to the Senate amendment struck out the text proposed by the Senate amendment and inserted a substitute text which was identical to the texts of H.R. 4974, H.R. 4975, and H.R. 4976, as passed by the House.

The Senate recedes from its disagreement to the amendment of the House with an amendment which is a substitute for the Senate amendment and the House amendment. The differences between the Senate amendment, the House amendment, and the substitute agreed to in conference are noted below, except for clerical corrections, conforming changes made necessary by agreements reached by the conferees, and minor drafting and clarifying changes.

AUTHORIZATIONS OF APPROPRIATIONS FOR HEALTH PROGRAMS

Both the House and Senate amendments to the House-passed bills authorized line-item appropriations for several health programs for fiscal year 1978. The following chart sets forth the authorizations in the Senate amendment, the House amendment, and the conference substitute.

	House amendment	Senate amendment	Conference substitute
Health services:			
314(d)(7)(A)—Bloc grants	103.5	110	106.75
314(d)(7)(B)—Hypertension	10.35	15	12.68
319(h)(1)—Migrant planning	1.8875	4	2.95
319(h)(2)—Migrant operation	29.1525	35	32.08
319(h)(3)—Migrant hospitalization	3.45	5	4.23
330(g)(1)—CHC planning	5.75	6	5
330(g)(2)—CHC operation	241.6702	272	256.84
1001(c)—Family planning projects	123.625	140	136.4
1003(b)—Family planning training	3.45	5	3
1004(b)—Family planning research	67.838	70	68.5
1005(b)—Family planning information	.69	2.5	.6
1121(b)—Sudden infant death syndrome	2.3	5	3.65
1131(f)—Hemophilia	3.45	5	4.55
1132(e)—Blood separation centers	3.45	4	3.45
Community Mental Health Centers Act:			
202(d)—CMHC planning	.1	3.75	1.93
203(d)—CMHC initial operation	22.775	55	38.89
204(c)—CMHC consultation and education	15	15	15
205(c)—CMHC conversion	22	24	23
213—CMHC financial distress	12	15	13.5
228—CMHC construction	0	5	2.5
231(d)—Rape prevention	5.75	10	7.88
Social Security Act:			
501—Maternal and child health [1]	383.8642	399.8642	399.8642
Public Law 94-63:			
602(a)—Home health services	8	8	8
602(b)—Home health training	4	4	4
Subtotal	1090.0623	1218.1142	1156.1242
Total, H.R. 4975	2960.1874	3509.7142	3357.0842

[1] Existing law provides that 22 percent of the appropriation made under sec. 1613 shall be made available for grants for construction or modernization projects designed to eliminate or prevent imminent safety hazards as defined by Federal, State, or local fire, building, or life safety codes or regulations, or avoid noncompliance with State or voluntary licensure or accreditation standards. The conference substitute authorizes appropriations of $67,500,000 in addition to the 22-percent earmark.

[2] No fiscal year limitation.

TECHNICAL AMENDMENTS TO HEALTH PLANNING LAW

Both the House and Senate amendments included technical amendments to the National Health Planning and Resources Development Act (Public Law 93-641).

The conference substitute combines the provisions of both amendments.

The managers wish to emphasize the need for a thorough review of implementation of this program by the new Administration. Several matters deserve the immediate attention of the Department of Health, Education, and Welfare.

First, the regulations governing a certificate of need program which must be developed by each state are deficient. The aggressive implementation of this section of the health planning legislation by the Department is necessary to effective control of capital expenditures, which is critical to containing exploding health care costs.

At the time that the Congress enacted Public Law 93-641, it was aware of the scope of coverage of section 1122 of the Social Security Act as it was then in effect. It was the intent of Congress that the certificate of need provisions of Public Law 93-641 have at least the same scope. The published regulations, however, do not require state certificate of need programs to cover organized ambulatory care programs, such as home health services; modernization of facilities; site acquisition; purchase of existing facilities; or the use of space within facilities leased to outside parties. Each of these activities was originally subject to review under section 1122 and in each case their exclusion will provide ways for hospitals, nursing homes and other health programs to circumvent the intent of this law. The omission of these activities from certificate of need regulations should be immediately reconsidered and rectified.

Second, the National Council on Health Planning and Development, established under title XV to advise the Secretary on a statement of national health planning goals and standards respecting the supply, distribution, and organization of health resources, has not been fully appointed and is not yet operational.

Third, the national guidelines for health planning have not yet been published. The issuance of such guidelines for use by health systems agencies and state health planning and development agencies was required by July 4, 1976. While a draft of the guidelines has been developed, it is deficient in that it includes few "standards respecting the appropriate supply, distribution, and organization of health resources" as required by section 1501. These standards are needed by health planning agencies to guide them in making proper policy decisions. Without them, each health systems agency and state health planning and development agency will be required to expend resources developing standards themselves to apply in their project review and planning functions.

Fourth, the Department has fallen behind on its publication of regulations essential to the implementation of the program. Especially crucial are those for state medical facilities and health plans and those for appropriateness review.

Fifth, Public Law 93-641 established ten regional centers to develop health planning methodology and technology and to support the technical assistance and manpower training needs of the health systems agencies (HSAs) and state health planning and development agencies (SHPDAs) in the ten HEW regions. These multidisciplinary centers for health planning are similar to the health service research centers funded by the National Center for Health Services Research. The Congress' intent was for these health planning centers to be entities separate from, although funded by, HEW in order that they be permitted to serve their primary constituents, HSAs and SHPDAs. These centers are not to be viewed as extensions of HEW regional offices, nor should they be required to provide any program support for the Department's staff. Further, the Department should authorize the centers to define priorities and work programs to meet the peculiar local or regional needs and priorities of HSAs and SHPDAs.

Sixth, the lack of progress in developing an evaluation methodology for reviewing the performance of the health systems agencies and state health planning and development agencies also is of concern to the conferees. Public Law 93-641 contains strong measures requiring such evaluation. Clearly the state of the art in evaluation of health planning is limited; nevertheless, HEW seems to have missed an opportunity over the last few years to promote research and demonstrations to further develop that state of the art. Health systems agencies and state agencies must develop a posture of competence, fairness and impartiality as well as begin to influence their health care delivery systems in positive ways. If planning is to be successful, the Federal Government must monitor the development of the planning system and take corrective action when problems are identified.

In this connection, the conferees were heartened to learn of the high standards which HEW is using in the review of health plans which HSAs develop. It is important that the initial health systems plans (HSP) both describe what additional services are needed to improve the health status of people and clearly identify excess capacity in the system, including the number and location of hospital beds and services that should be closed or converted to other uses, although the ability and advisability of HSAs providing such specificity in intial plans will vary due to social, legal and political factors. In determining whether an HSA is ready for full designation, HEW should continue to assure that its HSP and other plans are specific enough to be useful in carrying out its review and other implementation functions.

Finally, the conferees note that significant policy authority has been delegated to the ten HEW regional offices during the implementation of the planning and resources development program. In some cases this delegation has been disruptive and has resulted in actions contrary to the intent of the Conferees. For example, some HEW regional administrators have imposed salary and administrative restrictions on HSA staff. This is clearly inappropriate and outside the scope of HEW authority in that control over internal management, staff salary and administrative practices has been provided to HSA boards, and not HEW, by statute. Further, although it is appropriate for regional offices to monitor the implementation of the program and offer technical assistance, health planning policy decisions respecting implementation are clearly the responsibility of the Bureau of Health Planning and Resource Development under the direction of the Secretary with consultation with the National Council on Health Planning and Development. Uniform implementation of national health policies can best be accomplished by central decision making and regional monitoring.

The conferees also wish to clarify the original intent of the Health Planning and Resources Development Act with respect to the composition of governing bodies of health systems agencies. Under the law (section 1512(b)(3)(C) of the Public Health Service Act) consumer representatives of governing bodies are to be "broadly representative of the social, economic, linguistic and racial populations" residing within the health service area. The conferees emphasize that, as the law states, the populations are to be broadly represented. Therefore, several different approaches to insuring meaningful involvement in HSA decisions by all segments of society are permissible. In particular, it was not the intent of the Congress in enacting this provision to mandate a quota system requiring the selection of representatives of a particular category strictly proportionate to its representation in the population of the area or to require that representatives of a category be members of the class they represent. Instead, the Congress intended that, in implementation of the requirement with respect to consumer representatives, health systems agencies have the flexibility to adopt selection processes most appropriate to local needs.

HEALTH MAINTENANCE ORGANIZATION AMENDMENTS

The House amendment contained a provision not included in the Senate amendment which prohibited payments under medicare and medicaid to health maintenance organizations whose memberships are made up of a majority of individuals who are recipients of benefits under medicare or medicaid. This provision was intended to correct technically deficient language in Public Law 94–460 to achieve the original Congressional policy.

The conference substitute conforms to the House amendment.

CONSULTANTS TO THE NATIONAL CANCER INSTITUTE

The Senate amendment contained a provision, not included in the House amendment, which increased the number of experts and consultants which the Director of the National Cancer Institute is authorized to hire under section 410 of the Public Health Service Act (PHS Act) from 100 to 200. If further authorized the reimbursement of such consultants' traveling expenses to and from their assignment locations.

The conference substitute would authorize the Director of the National Cancer Institute to hire 51 additional experts and consultants, or a total of 151. It does not authorize the reimbursement of consultants for traveling expenses to and from their assignment locations.

AMBULATORY TREATMENT OF HYPERTENSION

The House amendment contained a provision, not included in the Senate amendment, which provided that grants under section 314(d)(7)(B) of the Public Health Service Act for programs for the screening, detection, diagnosis, prevention, and referral for treatment of hypertension could also be used to provide ambulatory care, where it is determined to be appropriate.

The conference substitute does not include the House provision. It is the intent of the conferees to wait until this program is substantially reevaluated later this year to determine whether the scope of the program should be expanded.

DEFINITION OF MEDICALLY UNDERSERVED POPULATION

The House amendment contained a provision, not included in the Senate amendment, which required the Secretary of HEW, in designating medically underserved populations under section 330 of the PHS Act for the purpose of making grants and awarding contracts for community health centers, to take into account unusual local conditions which are a barrier to access to or the availability of personal health services.

The conference substitute conforms to the House amendment.

ADMINISTRATIVE COSTS OF FAMILY PLANNING RESEARCH

The House amendment contained a provision, not included in the Senate amendment, intended to make it clear that the existing prohibition on the use of funds under the authority of the Public Health Service Act other than section 1004 (relating to authorizations for

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family planning research) includes the administrative costs of family planning research activities.

The conference substitute conforms to the House amendment. In including this provision, it is not the intent of the conferees to reduce the amount of support available for population research excluding administrative costs. The conferees intend that this new provision—which clarifies the intention of Congress that the entire population research effort of the Department of Health, Education, and Welfare be conducted under section 1004 of the PHS Act—not be used to reduce the appropriate program support level for population research.

GOVERNING BOARDS OF COMMUNITY AND MIGRANT HEALTH CENTERS

It has come to the attention of the conferees that the requirements that community and migrant health centers establish governing boards composed of individuals a majority of whom are served by the center and who represent the individuals being served by the center has been interpreted by the Department of Health, Education, and Welfare in a manner which may preclude public entities such as State and local governments from submitting approvable applications.

Under the law, each community and each migrant health center is to have a governing board which shall meet once a month, shall establish general policies for the center (including the selection of services to be provided and a schedule of hours during which services will be provided), approve the center's annual budget, and approve the selection of the director of the center. These minimum responsibilities are delineated under sections 319 and 330 of the Public Health Service Act. While other responsibilities may be delegated to the governing board, no requirements for additional responsibilities are to be imposed which could preclude in any way the submission of an approvable application under either section 319 or 330 of the Act by public entities including State and local governments and health departments. The law is clear that both public and nonprofit private entities are eligible grant recipients, and Department regulations may not alter that stipulation.

AMENDMENTS TO HEALTH PROFESSIONS EDUCATIONAL ASSISTANCE ACT OF 1976 (PUBLIC LAW 94-484)

Both the House and Senate amendments to the House-passed bill included provisions amending various authorities of the Health Professions Educational Assistance Act of 1976 (Public Law 94-484). The principal differences between the House and Senate amendments and the conference substitute are noted below.

Loan forgiveness under guaranteed student loan program

The Senate amendment contained a provision not included in the House amendment which conformed the financial obligation in the written contract which a borrower enters into with the Secretary of HEW under the loan forgiveness provision (section 735 of the PHS Act) of the guaranteed student loan program to that entered into by a participant in the National Health Service Corps scholarship program.

mum flexibility in determining what may be the most appropriate form for public health service program standards. The conferees are aware of the recent efforts of the Association of State and Territorial Health Officials, the National Association of County Health Officials, the United States Conference of City Health Officers, and the American Public Health Association, with staff support from the Center for Disease Control, to develop such standards on a voluntary, collaborative basis. The conferees anticipate that the Secretary will rely on the experience and advice of these groups, and support their continued efforts as a basis for both the form and content of public health program standards development required in this section.

STUDIES OF INTERNATIONAL HEALTH ISSUES AND OPPORTUNITIES

The Senate amendment contained a provision not included in the House amendment which directed the Secretary of HEW to arrange for the conduct of a study or studies to determine opportunities, if any, for broadened Federal program activities in areas of international health.

The conference substitute conforms to the Senate amendment.

Edward M. Kennedy,
Harrison A. Williams, Jr.,
Claiborne Pell,
Gaylord Nelson,
Alan Cranston,
William D. Hathaway,
Jacob Javits,
Richard S. Schweiker,
John H. Chafee,
Managers on the part of the Senate.
Harley O. Staggers,
Paul Rogers,
David Satterfield,
Tim Lee Carter,
James T. Broyhill,
Managers on the part of the House.

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Finder's Aid

P.L. 95-142 (91 Stat. 1175) Approved October 25, 1977
Medicare-Medicaid Anti-Fraud & Abust Amendments

Subject	SS Act Section	P.L. Sec.	91 Stat.	H.Rep. 95-393-I	H.Rep. 95-393-II	S.Rep. 95-453	H.C.Rep. 95-673
Professional Standards Review Organizations (PSRO) in South Pacific (Medical Officers)	1101(a)(1)	5(1)(2)	1191	61	68	24	--
Shared Health Facility	1101(a)(9)	5(c)(2)	1184	86-87	45	15-17	--
Uniform Reporting--Health Services	1121	19(a)	1203	74-75 105-106	82-83	38-39	47
Disclosure of Ownership, etc.	1124	3(a)(1)	1177	45-48	50-52	2 8-10	40
Issuance of Subpenas by Comptroller General	1125	6	1192	61-62	68-69	3 25-26	44
Disclosure by Institutions, etc.	1126	8(a)	1194	64-65	71-73	2-3 27-29	--
Technical Amendment	1152(b)(1)(A)	5(o)(1)	1191	--	--	25	--
PSRO Formation (Technical Amendment)	1152(b)(2)	5(d)(2)(A)	1185	87	--	17-21	--
PSRO (Technical Amendment)	1152(e)	5(a)	1183	50-51	55	14	--
State Health Care Facility Plans	1152(h)	5(d)(2)(B)	1185	87-88	--	--	--
Conditionally Designated PSRO's (Technical Amendment)	1154(b)	5(b)(1)	1184	51	55	4 14-15	--
Extended PSRO Trial Period	1154(c)	5(b)(2)	1184	51, 86	55-56	14-15	--
Renumbering (Technical)	1154(d)	5(b)(2)	1184	--	--	--	--
PSRO--Conditional Review (Technical)	1154(e)	5(d)(2)(c)	1186	88	--	17-21	--
Providers (Technical)	1155(a)(1)	5(d)(3)(B)	1188	90	--	17-21	--
PSRO (Technical)	1155(a)(1)	5(o)(2)	1191	--	--	25	--
PSRO--Physician Review	1155(a)(5)	5(p)	1192	--	--	25	44
PSRO--Redefining Physician Review Standards	1155(a)(6)(A)	5(c)(1)(A)	1184	52-54	58	15-17	--
PSRO--Redefining Physician Review Standards	1155(a)(6)(B)	5(c)(1)(B)	1184	52-53	58	15-17	--
PSRO--Primacy Intermediate Care Facility	1155(a)(7)	5(d)(3)(B)	1188	54-55	--	17-21	43
PSRO--Skilled Nursing Facilities	1155(e)(1)	5(d)(3)(A)	1188	54-55	61	17-21	43

Subject	SS Act Section	P.L. Sec.	91 Stat.	H.Rep. 95-393-I	H.Rep. 95-393-II	S.Rep. 95-453	H.C.Rep. 95-673
PSRO--Assistance Agreement	1155(f)(3)	5(c)(1)(C)	1184	--	--	17	41
PSRO--Ambulatory Care Methodology	1155(g)	5(c)(1)(D)	1184	52-54	56-58	4 15-17	41-42
Abolition of Program Review Teams (Medicare)	1157	13(b)(4)	1198	67-68	--	4, 32	--
Grace Period--Institutional Care (Technical)	1158(a)	22(a)	1208	--	--	42-43	49
Conclusive Determinations	1158(c)	5(d)(1)	1185	54-57	58-61	17-21	--
PSRO--Grace Period--Institutional Care	1158(d)	22(a)	1208	--	--	42-43	49
PSRO--Application of Sanctions (Technical Amendment)	1160(b)(1)	5(e)	1189	--	61-62	21	--
Technical Amendment	1160(b)(1)	5(o)(3)	1191	--	--	25	--
National Professional Standards Review Council	1163(a)(2)	5(f)	1189	57	62	21	43-44
Deletion of Reporting Requirement	1163(f)	5(g)	1189	57	62	21-22	--
Disclosure of Information	1166(a)	5(h)(1)-(2)	1189	58-59	147-153 62-63	22-23	--
Disclosure of Information	1166(b)	5(h)(3)-(4)	1189	58-59	147-153 62-63	22-23	--
Disclosure of Information	1166(c)	5(h)(3)	1189	--	147-153 62-63	22-23	--
Disclosure of Information	1166(d)	5(h)(5)	1190	--	147-153 62-63	22-23	--
Professional Standards Review--Legal Liability	1167	5(n)(6)	1191	--	--	24	--
Professional Standards Review--Legal Liability	1167(a)	5(n)(1)(2)	1191	--	--	24	--
Professional Standards Review--Legal Liability	1167(b)(1)	5(n)(3)(4)(5)	1191	--	--	24	--
Legal Expenses	1167(d)	5(i)	1190	91	63	4, 23	--
Funds Transfer	1168	5(j)	1190	--	63	23	--
Memos of Understanding--Federal-State Relations	1171	5(d)(2)(D)	1186	--	--	17-21	--
Annual Report on PSRO Program	1172	5(k)	1190	--	--	4 23-24	44
Medical Officers in South Pacific	1173	5(l)(1)	1191	61	68	24	--
Medicare Payment for VA Services	1814(c)	23(a)	1208	--	--	45	50

Subject	SS Act Section	P.L. Sec.	91 Stat.	H.Rep. 95-393-I	H.Rep. 95-393-II	S.Rep. 95-453	H.C.Rep. 95-673
Medicare Payment for VA Services	1814(j)	23(b)	1208	--	--	45	50
Anti-Factoring Provisions	1815(c)	2(a)(2)	1175	43-45	--	6-8	--
Fiscal Intermediaries	1816(a)	14(a)	1198	68-70	--	32-33	45-46
Standards for Better Administrative Pay Methods	1816(b)	14(a)(2)	1198	68-70	42-43	--	45-46
Standards for Better Administrative Pay Methods	1816(e)	14(a)(5)	1199	68-70	--	--	--
Standards for Better Administrative Pay Methods	1816(e)(2)	14(a)(3)	1198	68-70	--	--	45-46
Standards for Better Administrative Pay Methods	1816(f)	14(a)(5)	1199	68-70	--	32-33	45-46
Provisions Re Termination	1816(g)	14(a)(4)	1198	--	--	--	--
Surety Bond	1816(h)	14(a)(4)	1198	--	--	--	--
Nonliability of Certifying Officer	1816(i)	14(a)(4)	1198	--	--	--	--
Payment for Durable Medical Equipment	1833(f)	16(a)	1200	70-71	78-79	6 33-34	--
Anti-reassignment or Power of Attorney	1842(b)(5)	2(a)(1)	1175	43-45	39-48	6-8	--
Disclosure of Ownership etc. (Technical)	1861(j)(11)	3(a)(2)	1178	45-48	50-52	2-3 8-10	--
Technical Amendment	1861(j)(13)	21(a)	1207	--	--	42	--
Protection of Patient's Personal Funds	1861(j)(14)	21(a)	1207	--	--	42	49
Provider Reports	1868(v)(1)(F)	19(b)(1)	1204	74-75	82-83	4	47
Medical Officers in South Pacific (Technical)	1861(w)(2)	5(m)	1191	61	68	24	--
Abolition of Medicare Program Review Teams	1862(d)(1)(B)	13(b)(1)	1198	67-68	75	--	--
Abolition of Medicare Program Review Teams--No Pay for Substandard Care (Technical)	1862(d)(1)(C)	13(b)(2)	1198	67-68	75	--	--
No Payment for Sub-standard Care (Technical)-Repeal	1862(d)(4)	13(a)	1197	67-68	75	--	--
Suspension of Convicted Physicians	1862(e)	7(a)	1192	62-64	69-71	2 26-27	44

Subject	SS Act Section	P.L. Sec.	91 Stat.	H.Rep. 95-393-I	H.Rep. 95-393-II	S.Rep. 95-453	H.C.Rep. 95-673
Disclosure by Providers of Certain Hirings	1866(a)(1)(C)	15(a)(1)	1200	70	78	3 33	—
Disclosure by Providers of Certain Hirings	1866(a)(1)(D)	15(a)(2)	1200	70	78	3 33	—
Disclosure of Wrongdoers	1866(a)(3)	8(b)(1)	1194	96-98	71-73	2-3	—
Disclosure of Wrongdoers	1866(b)(2)	8(b)(2)	1195	96-98	71-73	—	—
Disclosure of Ownership or Control	1866(b)(2)(C)	3(b)	1178	—	—	2 8-10	40
No Provider Pay for Poor or Excess Care	1866(b)(2)(F)	13(b)(3)	1198	—	—	—	—
Fraud Penalties	1877	4(a)	1179	—	—	1-2 10-14	—
Effective Date	1902(a)	—	1177	—	—	—	—
Registered Nurses on PSRO in Skilled Nursing Facilities	1902(a)(26)	20(b)	1207	—	—	—	49
Federal Access to State Medicaid Records	1902(a)(27)(B)	9	1195	65	73	3 29	—
Anti-Factoring Provisions	1902(a)(32)	2(a)(3)	1176	—	—	6-8	—
Intermediate Care Facility Subject to Disclosure of Ownership (Technical)	1902(a)(35)	2(b)(1)(A)	1176	—	—	—	—
Intermediate Care Facility Subject to Disclosure of Ownership (Technical)	1902(a)(35)	3(c)(1)(A)	1178	45-48	50-52	8-10	40
Technical Amendment	1902(a)(36)	2(b)(1)(B)	1176	—	—	—	—
Technical Amendment	1902(a)(36)	3(c)(1)(B)	1178	—	—	—	—
Medicaid Claims Payment Procedures	1902(a)(37)	2(b)(1)(C)	1176	45	49-50	5 6-8	40
Technical Amendment	1902(a)(37)	3(c)(1)(C)	1178	—	—	—	—
Technical Amendment	1902(a)(37)	7(b)(1)	1193	—	—	—	—
Subcontractor Disclosure of Ownership, etc.	1902(a)(38)	3(c)(1)(D)	1178	45-48	50-52	8-10	40
Technical Amendment	1902(a)(38)	7(b)(2)	1193	—	—	—	—
Technical Amendment	1902(a)(38)	19(b)(2)(A)	1204	—	—	—	—
Suspension of Physicians	1902(a)(39)	7(b)(3)	1193	62-64	69-71	2 26-27	44
Technical Amendment	1902(a)(39)	19(b)(2)(B)	1204	—	—	—	—
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Subject	SS Act Section	P.L. Sec.	91 Stat.	H.Rep. 95-393-I	H.Rep. 95-393-II	S.Rep. 95-453	H.C.Rep. 95-673
Mechanized State Processing	1903	10(a)	1195	65-66	73-74	29-30	--
Funding of State Fraud Control Units	1903(a)(6)	17(a)	1201	--	--	5 34-37	46-47
Technical Amendment	1903(a)(7)	17(a)	1201	--	--	34-37	--
Funding Limit	1903(b)(3)	17(b)	1201	--	--	5 34-37	46
Technical Amendment	1903(g)(1)	20(a)(1)(2)	1205	--	--	--	--
Technical Amendment	1903(g)(2)	20(a)(3)	1205	--	--	--	--
Federal-State Tensions re Medicaid Utilization Control	1903(g)(3)	20(a)(4)	1205	--	83-86	39-42	47-48
Federal-State Provisions	1903(g)(4)	20(a)(4)	1205	--	83-86	39-42	47-48
Federal-State Provisions	1903(g)(5)	20(a)(4)	1205	--	83-86	39-42	47-48
Federal-State Provisions	1903(g)(6)	20(a)(4)	1205	--	83-86	39-42	47-48
Technical Amendment	1903(i)(2)	3(c)(2)	1179	--	--	--	--
Disclosure of Fraud Doers	1903(n)	8(c)	1195	64-65	71-73	27-29	--
Third Party Liability (Medicaid)	1903(o)	11(a)	1196	66	74	30-31	45
Third Party Liability (Medicaid) (Incentive Payment)	1903(p)	11(a)	1196	66	74	30-31	45
State Medicaid Fraud Control	1903(q)	17(c)	1201	71-73	79-81	5 34-37	46-47
Penalties for Fraud	1909	4(b)	1181	48-50	52-55	1-2 10-14	41
Assignment of Third Party Rights	1912	11(b)	1196	66	74	30-31	45
Disclosure of Ownership, etc.	2002(a)(15)	3(d)(2)	1179	45-48	50-52	8-10	40
Disclosure of Convictions	2002(a)(16)	8(d)	1195	64-65	71-73	27-29	--
Technical Amendment	2003(d)(1)(H)	3(d)(1)(A)	1179	--	--	--	--
Technical Amendment	2003(d)(1)(I)	3(d)(1)(B)	1179	--	--	--	--
Disclosure of Ownership	2003(d)(1)(J)	3(d)(1)(C)	1179	45-48	50-52	8-10	40

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Public Law 95-142
95th Congress

An Act

To strengthen the capability of the Government to detect, prosecute, and punish fraudulent activities under the medicare and medicaid programs, and for other purposes.

Oct. 25, 1977
[H.R. 3]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Medicare-Medicaid Anti-Fraud and Abuse Amendments.
42 USC 1305 note.

SHORT TITLE

SECTION 1. This Act may be cited as the "Medicare-Medicaid Anti-Fraud and Abuse Amendments".

PROHIBITION AGAINST ASSIGNMENT BY PHYSICIANS AND OTHERS OF CLAIMS FOR SERVICES; CLAIMS PAYMENT PROCEDURES FOR MEDICAID PROGRAM

Carrier contracts.
42 USC 1395u.

SEC. 2. (a)(1) Section 1842(b)(5) of the Social Security Act is amended by adding at the end thereof the following new sentence: "No payment which under the preceding sentence may be made directly to the physician or other person providing the service involved (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) shall be made to anyone else under a reassignment or power of attorney (except to an employer or facility as described in clause (A) or (B) of such sentence); but nothing in this subsection shall be construed (i) to prevent the making of such a payment in accordance with an assignment from the individual to whom the service was provided or a reassignment from the physician or other person providing such service if such assignment or reassignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (ii) to preclude an agent of the physician or other person providing the service from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such physician or other person under this title is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment.".

42 USC 1395g.

(2) Section 1815 of such Act is amended by adding at the end thereof the following new subsection:

"(c) No payment which may be made to a provider of services under this title for any service furnished to an individual shall be made to any other person under an assignment or power of attorney; but nothing in this subsection shall be construed (1) to prevent the making of such a payment in accordance with an assignment from the provider if such assignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (2) to preclude an agent of the provider of services from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for on in connection with the billing or collection of payments due such provider under this title is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment.".

State plans for medical assistance.
42 USC 1396a.

(3) Section 1902(a)(32) of such Act is amended to read as follows:

"(32) provide that no payment under the plan for any care or service provided to an individual shall be made to anyone other than such individual or the person or institution providing such care or service, under an assignment or power of attorney or otherwise; except that—

"(A) in the case of any care or service provided by a physician, dentist, or other individual practitioner, such payment may be made (i) to the employer of such physician, dentist, or other practitioner if such physician, dentist, or practitioner is required as a condition of his employment to turn over his fee for such care or service to his employer, or (ii) (where the care or service was provided in a hospital, clinic, or other facility) to the facility in which the care or service was provided if there is a contractual arrangement between such physician, dentist, or practitioner and such facility under which such facility submits the bill for such care or service; and

"(B) nothing in this paragraph shall be construed (i) to prevent the making of such a payment in accordance with an assignment from the person or institution providing the care or service involved if such assignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (ii) to preclude an agent of such person or institution from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such person or institution under the plan is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment;".

Effective date.
42 USC 1395g note.

(4) The amendments made by this subsection shall apply with respect to care and services furnished on or after the date of the enactment of this Act.

(b)(1) Section 1902(a) of the Social Security Act is amended—

(A) by striking out "and" at the end of paragraph (35);

(B) by striking out the period at the end of paragraph (36) and inserting in lieu thereof "; and";

Claims payment procedures.

(C) by inserting immediately after paragraph (36) the following new paragraph:

"(37) provide for claims payment procedures which (A) ensure that 90 per centum of claims for payment (for which no further written information or substantiation is required in order to make payment) made for services covered under the plan and furnished by health care practitioners through individual or group practices or through shared health facilities are paid within 30 days of the date of receipt of such claims and that 99 per centum of such claims are paid within 90 days of the date of receipt of such claims, and (B) provide for procedures of prepayment and postpayment claims review, including review of appropriate data with respect to the recipient and provider of a service and the nature of the service for which payment is claimed, to ensure the proper and efficient payment of claims and management of the program."; and

(D) by inserting at the end thereof the following paragraph: "The requirement of clause (A) of paragraph (37) with respect to State plan may be waived by the Secretary if he finds that the State as exercised good faith in trying to meet such requirement.".

State plans, waiver.

(2) The amendments made by paragraph (1) shall apply to calen- ar quarters beginning on and after July 1, 1978, with respect to State lans approved under title XIX of the Social Security Act.

Effective date.
42 USC 1396a note.
42 USC 1396.

DISCLOSURE OF OWNERSHIP AND RELATED INFORMATION

Sec. 3. (a)(1) Part A of title XI of the Social Security Act is mended by inserting immediately after section 1123 the following ew section:

Regulations.
42 USC 1301.

"DISCLOSURE OF OWNERSHIP AND RELATED INFORMATION

"Sec. 1124. (a)(1) The Secretary shall by regulation or by con- ract provision provide that each disclosing entity (as defined in para- raph (2)) shall—

42 USC 1320a-3.

"(A) as a condition of the disclosing entity's participation in, or certification or recertification under, any of the programs established by titles V, XVIII, XIX, and XX, or

42 USC 701, 1395, 1396, 1397.

"(B) as a condition for the approval or renewal of a contract or agreement between the disclosing entity and the Secretary or the appropriate State agency under any of the programs established under titles V, XVIII, XIX, and XX,

upply the Secretary or the appropriate State agency with full and omplete information as to the identity of each person with an owner- hip or control interest (as defined in paragraph (3)) in the entity or n any subcontractor (as defined by the Secretary in regulations) in hich the entity directly or indirectly has a 5 per centum or more wnership interest.

"(2) As used in this section, the term 'disclosing entity' means an ntity which is—

Definitions.

"(A) a provider of services (as defined in section 1861(u), other than a fund), an independent clinical laboratory, a renal disease facility, or a health maintenance organization (as defined in section 1301(a) of the Public Health Service Act);

42 USC 300e.

"(B) an entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, items or services with respect to which payment may be claimed by the entity under any plan or program established pursuant to title V or under a State plan approved under title XIX;

"(C) a carrier or other agency or organization that is acting as a fiscal intermediary or agent with respect to one or more providers of services (for purposes of part A or part B of title XVIII, or both, or for purposes of a State plan approved under title XIX) pursuant to (i) an agreement under section 1816, (ii) a contract under section 1842, or (iii) an agreement with a single State agency administering or supervising the administration of a State plan approved under title XIX; or

Post, p. 1198.
Ante, p. 1175.

"(D) an entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health related services with respect to which payment may be claimed by the entity under a State plan or program approved under title XX.

"(3) As used in this section, the term 'person with an ownership or control interest' means, with respect to an entity, a person who—

"(A)(i) has directly or indirectly (as determined by the Secretary in regulations) an ownership interest of 5 per centum or more in the entity; or

"(ii) is the owner (in whole or in part) of an interest of 5 per centum or more in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity or any of the property or assets thereof; or

"(B) is an officer or director of the entity, if the entity is organized as a corporation; or

"(C) is a partner in the entity, if the entity is organized as a partnership.

"(b) To the extent determined to be feasible under regulations of the Secretary, a disclosing entity shall also include in the information supplied under subsection (a)(1), with respect to each person with an ownership or control interest in the entity, the name of any other disclosing entity with respect to which the person is a person with an ownership or control interest.".

42 USC 1395x.

(2) Section 1861(j)(11) of such Act is amended to read as follows:

"(11) complies with the requirements of section 1124;".

Agreements.
42 USC 1395cc.

(b) Clause (C) of section 1866(b)(2) of such Act is amended by inserting "(i)" after "failed", and by adding after "to verify such information," the following: "or (ii) to supply (within such period as may be specified by the Secretary in regulations) upon request specifically addressed to such provider by the Secretary (I) full and complete information as to the ownership of a subcontractor (as defined by the Secretary in regulations) with whom such provider has had, during the previous twelve months, business transactions in an aggregate amount in excess of $25,000, and (II) full and complete information as to any significant business transactions (as defined by the Secretary in regulations), occurring during the five-year period ending on the date of such request, between such provider and any wholly owned supplier or between such provider and any subcontractor,".

42 USC 1396a.

(c)(1) Section 1902(a) of such Act (as amended by section 2(b)(1) of this Act) is amended—

(A) by amending paragraph (35) to read as follows:

"(35) provide that any intermediate care facility receiving payments under such plan complies with the requirements of section 1124;";

Ante, p. 1177.

(B) by striking out "and" at the end of paragraph (36);

(C) by striking out the period at the end of paragraph (37) and inserting in lieu thereof "; and"; and

Business records, availability.

(D) by inserting after paragraph (37) the following new paragraph:

"(38) require that an entity (other than an individual practitioner or a group of practitioners) that furnishes, or arranges for the furnishing of, items or services under the plan, shall supply (within such period as may be specified in regulations by the Secretary or by the single State agency which administers or supervises the administration of the plan) upon request specifically addressed to such entity by the Secretary or such State agency, respectively, (A) full and complete information as to the ownership of a subcontractor (as defined by the Secretary in regulations) with whom such entity has had, during the previous twelve months, business transactions in an aggregate amount in excess of $25,000, and (B) full and complete information as to any significant business transactions (as defined by the Secretary in regulations), occurring during the five-year period ending on the date of such request, between such entity and any wholly owned supplier or between such entity and any subcontractor.".

(2) Section 1903(i)(2) of such Act is amended by inserting before he semicolon at the end thereof the following: ", or by reason of oncompliance with a request made by the Secretary under clause C)(ii) of such section 1866(b)(2) or under section 1902(a)(38)".

42 USC 1396b.
42 USC 1395cc.
42 USC 1396a.

(d)(1) Section 2003(d)(1) of such Act is amended—

42 USC 1397b.

(A) by striking out "and" at the end of subparagraph (H);

(B) by striking out the period at the end of subparagraph (I) and inserting in lieu thereof "; and"; and

(C) by adding after subparagraph (I) the following new subparagraph:

Business records, availability.

"(J) provides that any entity (other than an individual practitioner or a group of practitioners) receiving payments for the provision of health related services complies with the requirements of section 1124, and supplies (within such period as may be specified in regulations by the Secretary or by the State agency which administers or supervises the administration of the plan) upon request specifically addressed to such entity by the Secretary or such State agency, respectively, (i) full and complete information as to the ownership of a subcontractor (as defined by the Secretary in regulations) with whom such entity has had, during the previous twelve months, business transactions in an aggregate amount in excess of $25,000, and (ii) full and complete information as to any significant business transactions (as defined by the Secretary in regulations), occurring during the five-year period ending on the date of such request, between such entity and any wholly owned supplier or between such entity and any subcontractor.".

Ante, p. 1177.

(2) Section 2002(a) of such Act is amended by adding at the end hereof the following new paragraph:

Payments to States.
42 USC 1397a.

"(15) No payment may be made under this section with respect to ny expenditure for the provision of any health related service if uch service is provided by an entity which has failed to comply with request made by the Secretary or State agency under section 2003 d)(1)(J), for so long as such entity remains in noncompliance with uch request.".

Supra.

(e) The amendment made by subsection (a)(1) shall apply with espect to certifications and recertifications made (and participation in he programs established by titles V, XVIII, XIX, and XX of the ocial Security Act pursuant to certifications and recertifications nade), and fiscal intermediary or agent agreements or contracts ntered into or renewed, on and after the date of the enactment of this ct. The remaining amendments made by this section shall take ffect on the date of the enactment of this Act; except that the amendents made by subsections (c) and (d) shall become effective Jan ary 1, 1978.

Effective dates.
42 USC 1320a-3 note.
42 USC 701, 1395, 1396, 1397.

ENALTIES FOR DEFRAUDING MEDICARE AND MEDICAID PROGRAMS

EC. 4. (a) Section 1877 of the Social Security Act is amended to ead as follows:

42 USC 1395nn.

"PENALTIES

"SEC. 1877. (a) Whoever—

Material facts, misrepresentation.

"(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under this title,

"(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to any such benefit or payment,

Fraudulently secured benefits.

"(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

Benefits, misuse.

"(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both.

Illegal remunerations.

"(b)(1) Whoever solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind—

"(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

"(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

"(2) Whoever offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person—

"(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

"(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

"(3) Paragraphs (1) and (2) shall not apply to—

"(A) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title; and

"(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

Health care facilities, condition or operation, misrepresentation.

"(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, or home health agency (as those terms are defined in section 1861), shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

"(d) Whoever accepts assignments described in section 1842(b)(3)(B)(ii) and knowingly, willfully, and repeatedly violates the term of such assignments specified in subclause (I) of such section, shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $2,000 or imprisoned for not more than six months, or both.".

(b) Section 1909 of such Act is amended to read as follows:

42 USC 1396h.

"PENALTIES

"Sec. 1909. (a) Whoever—

Misrepresentation of material facts.

"(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a State plan approved under this title,

"(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,

Fraudulently secured benefits.

"(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

Benefits, misuse.

"(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000

State benefits, eligibility restrictions.

or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a State plan approved under this title is convicted of an offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of this title or of such plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

Illegal remunerations.

"(b)(1) Whoever solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind—

"(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

"(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

"(2) Whoever offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person—

"(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

"(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

"(3) Paragraphs (1) and (2) shall not apply to—

"(A) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title; and

"(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

Health care facilities, condition or operation, misrepresentation.

"(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, intermediate care facility, or home health agency (as those terms are employed in this title) shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

Health care facilities, illegal patient admittance and retention practices.

"(d) Whoever knowingly and willfully—

"(1) charges, for any service provided to a patient under a State plan approved under this title, money or other consideration at a rate in excess of the rates established by the State, or

"(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under this title, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)—

"(A) as a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility, or

"(B) as a requirement for the patient's continued stay in such a facility,

when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan,

shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.".

Reports to Congress, contents.

(c) Section 204(a) of Public Law 94–505 (42 U.S.C. 3524) (relating to annual reports of the Health, Education, and Welfare Inspector General) is amended by adding at the end thereof the following sentences: "Such report also shall include a detailed description of the cases referred by the Department of Health, Education, and Welfare to the Department of Justice during the period covered by the report, an evaluation of the performance of the Department of Justice in the investigation and prosecution of criminal violations relating to fraud in the programs of health insurance and medical assistance provided under titles XVIII and XIX of the Social Security Act, and any recommendations with respect to improving the performance of such activities by the Department of Justice. Promptly, after the Inspector General submits such a report to Congress, the Attorney General shall report to Congress concerning the details of the disposition of the cases referred to the Department of Justice and described in the Inspector General's report.".

42 USC 1395, 1396.

Effective date. 42 USC 1395nn note.

(d) The amendments made by subsections (a) and (b) shall apply with respect to acts occurring and statements or representations made on or after the date of the enactment of this Act.

AMENDMENTS RELATED TO PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

42 USC 1320c–1.

SEC. 5. (a) Section 1152(e) of the Social Security Act is amended to read as follows:

"(e) Where the Secretary finds a Professional Standards Review Organization (whether designated on a conditional basis or otherwise) to be competent to perform review responsibilities, the review, certification, and similar activities otherwise required pursuant to provisions of this Act (other than this part) shall not be applicable with respect to those providers, suppliers, and practitioners being reviewed by such Professional Standards Review Organization, except to the extent specified by the Secretary. Nothing in the preceding sentence shall be construed as rendering inapplicable any provision of this Act wherein requirements with respect to conditions for eligibility to or payment of benefits (as distinct from reviews and certifications made with respect to determinations of the kind made pursuant to paragraphs (1) and (2) of section 1155(a)) must be satisfied.".

42 USC 1320c–4.

42 USC 1320c-3.

(b) (1) Section 1154(b) of such Act is amended—

(A) by striking out "(which may not exceed 24 months)" in the first sentence and inserting in lieu thereof "(which may not exceed 48 months except as provided in subsection (c))";

(B) by inserting ", in addition to review of health care services provided by or in institutions," in the first sentence after "perform"; and

(C) by striking out "or ordered by physicians" and all that follows through "and organizations" in the second sentence and inserting in lieu thereof "by or in institutions (including ancillary services), and, in addition, review of such other health care services as the Secretary may require".

Trial period, extension.

(2) Section 1154 of such Act is further amended by redesignating subsection (c) as subsection (d) and by inserting after subsection (b) the following new subsection:

"(c) If the Secretary finds that an organization designated under subsection (a) has been unable to perform satisfactorily all of the duties and functions required under this part for reasons beyond the organization's control, he may extend such organization's trial period for an additional period not exceeding twenty-four months.".

42 USC 1320c-4.

(c) (1) Section 1155 of such Act is amended—

(A) by striking out "directly or indirectly involved in" in subsection (a)(6)(A) and inserting in lieu thereof "directly responsible for";

(B) by striking out "any financial" in subsection (a)(6)(B) and inserting in lieu thereof "a significant financial";

Grants.

(C) by inserting after subsection (f)(2) the following new paragraph:

"(3) Any such agreement with an organization under this part may be in the form of a grant or an assistance agreement."; and

Review responsibility requests.

(D) by striking out subsection (g) and inserting in lieu thereof the following new subsection:

"(g)(1) Where a Professional Standards Review Organization (whether designated on a conditional basis or otherwise) requests review responsibility with respect to services furnished in shared health facilities, the Secretary must give priority to such request, with the highest priority being assigned to requests from organizations located in areas with substantial numbers of shared health facilities.

Ambulatory care services, review.

"(2) The Secretary shall require any Professional Standards Review Organization which is capable of exercising review responsibility with respect to ambulatory care services to perform review responsibility with respect to such services on and after a date not earlier than the date the organization is designated as a Professional Standards Review Organization (other than under section 1154) and not later than two years after the date the organization has been so designated, but any such designated Professional Standards Review Organization may be approved to perform such review responsibility at any earlier time if such organization applies for, and is found capable of exercising, such responsibility.".

"Shared health facility."
42 USC 1301.

(2) Section 1101(a) of such Act is amended by inserting after paragraph (8) the following new paragraph:

"(9) The term 'shared health facility' means any arrangement whereby—

"(A) two or more health care practitioners practice their professions at a common physical location;

"(B) such practitioners share (i) common waiting areas, examining rooms, treatment rooms, or other space, (ii) the services of supporting staff, or (iii) equipment;

"(C) such practitioners have a person (who may himself be a practitioner)—

"(i) who is in charge of, controls, manages, or supervises substantial aspects of the arrangement or operation for the delivery of health or medical services at such common physical location, other than the direct furnishing of professional health care services by the practitioners to their patients; or

"(ii) who makes available to such practitioners the services of supporting staff who are not employees of such practitioners;

and who is compensated in whole or in part, for the use of such common physical location or support services pertaining thereto, on a basis related to amounts charged or collected for the services rendered or ordered at such location or on any basis clearly unrelated to the value of the services provided by the person; and

"(D) at least one of such practitioners received payments on a fee-for-service basis under titles V, XVIII, and XIX in an amount exceeding $5,000 for any one month during the preceding 12 months or in an aggregate amount exceeding $40,000 during the preceding 12 months;

42 USC 701, 1395, 1396.

except that such term does not include a provider of services (as defined in section 1861(u) of this Act), a health maintenance organization (as defined in section 1301(a) of the Public Health Service Act), a hospital cooperative shared services organization meeting the requirements of section 501(e) of the Internal Revenue Code of 1954, or any public entity.".

42 USC 1395.
42 USC 300e.
26 USC 501.

(d)(1) Section 1158 of such Act is amended by adding at the end thereof the following new subsection:

Claim payments review.
42 USC 1320c-7.

"(c) Where a Professional Standards Review Organization (whether designated on a conditional basis or otherwise) has been found competent by the Secretary to assume review responsibility with respect to specified types of health care services or specified providers or practitioners of such services and is performing such reviews, determinations made pursuant to paragraphs (1) and (2) of section 1155(a) in connection with such reviews shall constitute the conclusive determination on those issues (subject to sections 1159, 1171(a)(1), and 1171(d)(3)) for purposes of payment under this Act, and no reviews with respect to those determinations shall be conducted, for purposes of payment, by agencies and organizations which are parties to agreements entered into by the Secretary pursuant to section 1816, carriers which are parties to contracts entered into by the Secretary pursuant to section 1842, or single State agencies administering or supervising the administration of State plans approved under title XIX.".

42 USC 1320c-4.
42 USC 1320c-8.
Post, p. 1186.
42 USC 1395h.
42 USC 1395u.

(2)(A) Section 1152(b)(2) of such Act is amended by striking out "submitted to him by the association, agency, or organization" and inserting in lieu thereof "which shall be developed and submitted by the association, agency, or organization in accordance with subsection (h)".

42 USC 1320c-1.

(B) Section 1152 of such Act is further amended by adding at the end thereof the following new subsection:

State health care facility plans, preparation.

"(h)(1) During the development and preparation by an organization of its formal plan under subsection (b)(2) or of any modification of such plan to include review of services in skilled nursing facilities (as defined in section 1861(j)) or intermediate care facilities (as defined in section 1905(c)) or review of ambulatory care services, the organization shall consult with the single State agency responsible

42 USC 1395x.
42 USC 1396d.

42 USC 1396.

for administering or supervising the administration of the State plan approved under title XIX for the State in which the organization is located.

"(2) Such plan and any such modification shall be submitted to the Governor of such State, at the time of its submission to the Secretary, for his comments.

"(3) The Secretary, before making the findings described in subsection (b)(2) or a finding regarding the organization's capability to perform review of such services (as the case may be), shall consider any such comments submitted to him by such Governor before the end of the thirty-day period beginning on the date of submission of the plan or of any such modification (as the case may be).

"(4) If, after considering such comments, the Secretary intends to make findings which are adverse to such comments, the Secretary shall provide the Governor making such comments with the opportunity to submit additional evidence and comments on such intended findings during a period of not less than thirty days ending before the findings became effective.".

Evaluation procedures.
Ante, p. 1184.

(C) Section 1154 of such Act (as amended by subsection (b)(2) of this section) is further amended by adding after subsection (d) the following new subsection:

"(e) In determining whether an organization designated on a conditional basis as the Professional Standards Review Organization for any area is substantially carrying out its duties in a satisfactory manner and should be considered a qualified organization, the Secretary shall follow the procedures specified in section 1152(h) (concerning the Secretary's consideration of comments of the Governor of the State in which the organization is located).".

Ante, p. 1185.

42 USC 1320c-19.

(D) Part B of title XI of such Act is amended by adding after section 1170 the following new section:

"MEMORANDUMS OF UNDERSTANDING; FEDERAL-STATE RELATIONS GENERALLY

42 USC 1320c-20.
42 USC 1320c-4.
Ante, p. 1185.
42 USC 1396.

"SEC. 1171. (a)(1) Except as provided in paragraph (2), no determination made by a Professional Standards Review Organization pursuant to paragraphs (1) and (2) of section 1155(a) in connection with reviews shall constitute conclusive determinations under section 1158(c) for purposes of payment under title XIX, unless such organization has entered into a memorandum of understanding, approved by the Secretary, with the single State agency responsible for administering or supervising the administration of the State plan approved under title XIX for the State in which the organization is located (hereinafter in this section referred to as the 'State agency') for the purpose of delineating the relationship between the organization and the State agency and of providing for the exchange of data or information, and for administrative procedures, coordination mechanisms, and modification of the memorandum at any time that additional responsibility for review by the organization is authorized by the Secretary.

Waiver.

"(2) The requirement of paragraph (1) may be waived by the Secretary if (A) the State agency indicates to the Secretary that it does not wish to enter into a memorandum of understanding with the organization involved, or (B) the Secretary finds that the State agency has refused to negotiate in good faith or in a timely manner with the organization involved.

Review goals and methods, specification.

"(b)(1) The State agency may request a Professional Standards Review Organization which is entering into such a memorandum of understanding with the agency to include in the memorandum a specification of review goals or methods (additional to any such goals or methods contained in the organization's formal plan) for the performance of the organization's duties and functions under this part.

"(2) If the agency and the organization cannot reach agreement regarding the inclusion of any such requested specification, the Secretary shall review such specification and shall require that the specification be included in the memorandum to the extent that the Secretary determines that such specification of goals or methods (A) is consistent with the functions of the organization under this part and with the provisions of title XIX and the State's plan approved under such title, and (B) does not seriously impact on the effectiveness and uniformity of the organization's review of health care services paid for under title XVIII and title XIX of this Act.

42 USC 1396.

42 USC 1395.

Additional State review requests.

"(c) Notwithstanding any other provision of this Act, the State agency may contract with any Professional Standards Review Organization located in the State for the performance of review responsibilities in addition to those performed pursuant to this part (and the cost of performance of such additional responsibilities is reimbursable as an expense of the State agency under section 1903(a)) if—

42 USC 1396b.

"(1) the State agency formally requests the performance of such additional responsibilities, and

"(2) the performance of such additional responsibilities is not inconsistent with this part and is provided for in an amendment to the State's plan which is approved by the Secretary under title XIX.

State monitoring plans.

"(d)(1) Each State agency may monitor the performance of review responsibilities by Professional Standards Review Organizations located within the State, in accordance with a State monitoring plan which is developed after review and comment by such organizations and is approved by the Secretary. The costs of activities of the State agency under and in accordance with such plan are reimbursable as an expense of the State agency under section 1903(a).

"(2) A monitoring plan developed and approved under paragraph (1) may include a specification of performance criteria for judging the effectiveness of the review performance of the Professional Standards Review Organizations. If the State agency and the Professional Standards Review Organizations cannot reach agreement regarding such criteria, the Secretary shall assist the agency and organizations in resolving the matters in dispute.

Review organization's authority, suspension.

"(3)(A) Whenever a State agency monitoring the performance of review responsibilities by a Professional Standards Review Organization under a plan developed and approved under paragraph (1) submits to the Secretary reasonable documentation that the review determinations of such organization have caused an unreasonable and detrimental impact on total State expenditures under title XIX and on the appropriateness of care received by individuals under the State's plan approved under such title, and requests the Secretary to act, the Secretary shall, within thirty days from the date of receipt of the documentation, make a determination as to the reasonableness of the allegation by the State agency. If the Secretary determines that the review determinations of such organization have caused an unreasonable and detrimental impact on total State expenditures under title XIX and on the appropriateness of care received by individuals under the State's plan approved under such title, unless the Secretary determines that

Ante, p. 1185.
42 USC 1396.
42 USC 1395.

the organization has taken appropriate corrective action, he shall immediately suspend such organization's authority in whole or in part under section 1158(c) to make conclusive determinations for purposes of payment under title XIX (and he may suspend such authority for purposes of payment under title XVIII) until he (i) reevaluates such organization's performance of the responsibilities involved and determines that such performance does not have such unreasonable and detrimental impact, or (ii) determines that the organization has taken appropriate corrective action. Any determination made by the Secretary under this subparagraph shall be final and shall not be subject to judicial review.

Notification of congressional committees.

"(B) The Secretary shall notify the State agency submitting such documentation, and the organization involved, in writing, of his determination, any subsequent actions taken, and the basis thereof, and shall notify the appropriate committees of the United States House of Representatives and the Senate of any such documentation submitted and the actions taken.

Procedures and mechanisms, development.

"(e)(1) The Secretary shall in a timely manner establish procedures and mechanisms to govern his relationships with State agencies under this part (specifically including his relationships with such agencies in connection with their respective functions under the preceding provisions of this section). Such mechanisms shall include periodic consultation by the Secretary with State agency representatives and representatives of Professional Standards Review Organizations regarding relationships between such agencies and such organizations (including the appropriate exchange of data and information between such agencies and such organizations) and other problems of mutual concern, and such procedures shall permit the State agency to be represented on any project assessments conducted by the Secretary with respect to a Professional Standards Review Organization located within its State.

"(2) Each Professional Standards Review Organization shall provide to the State agency for the State in which it is located, upon request, data or information which the Secretary requires such organizations to report to him routinely on a periodic basis, and such other data or information as the Secretary authorizes to be disclosed.".

Review committees of hospitals and other health care facilities.
42 USC 1320c-4.
Post, p. 1207.
42 USC 1396d.

(3)(A) Section 1155(e)(1) of such Act is amended by striking out "of a hospital or other operating health care facility or organization" and inserting in lieu thereof "of a hospital (including any skilled nursing facility, as defined in section 1861(j), or intermediate care facility, as defined in section 1905(c), which is also a part of such hospital) or other operating health care facility or organization (other than such a skilled nursing facility or intermediate care facility which is not a part of a hospital)".

(B) Section 1155(a) of such Act is amended—

(i) by inserting "(except as provided in paragraph (7))" in paragraph (1) after "institutional and noninstitutional providers of health care services"; and

(ii) by inserting after paragraph (6) the following new paragraph:

"(7)(A) Except as provided in subparagraph (B), a Professional Standards Review Organization located in a State has the function and duty to assume responsibility for the review under paragraph (1) of professional activities in intermediate care facilities (as defined in section 1905(c)) and in public institutions for the mentally retarded (described in section 1905(d)(1)) only if (i) the Secretary finds, on the basis of such documentation as he may require from the State, that the single State agency which administers or supervises the administration of the State plan approved under title XIX for that State is not performing effective review of the quality and necessity of health care services provided in such facilities and institutions, or (ii) the State requests such organization to assume such responsibility.

42 USC 1396.

"(B) A Professional Standards Review Organization located in a State has the function and duty to assume responsibility for the review under paragraph (1) of professional activities in intermediate care facilities in the State that are also skilled nursing facilities (as defined in section 1861(j)), to the extent that the Secretary finds that the performance of such function by the single State agency (described in subparagraph (A)) for that State is inefficient.".

***Post,* p. 1207.**

(e) Section 1160(b)(1) of such Act is amended by striking out "practitioner or provider" and inserting in lieu thereof "health care practitioner or hospital, or other health care facility, agency, or organization" each time it appears therein.

42 USC 1320c-9.

(f) Section 1163(a)(2) of such Act is amended to read as follows:

"(2) Members of the Council shall be appointed for a term of three years, except that the Secretary may provide, in the case of any terms scheduled to expire after January 1, 1978, for such shorter terms as will ensure that (on a continuing basis) the terms of no more than four members expire in any year. Members of the Council shall be eligible for reappointment.".

National Professional Standards Review Council members, term.
42 USC 1320c-12.

(g) Section 1163 of such Act is amended by striking out subsection (f).

(h) Section 1166 of such Act is amended—

Data and information.
42 USC 1320c-15.

(1) by striking out "or (2)" in subsection (a) and inserting in lieu thereof ", (2)";

(2) by inserting the following immediately before the period at the end of subsection (a): ", or (3) in accordance with subsection (b)";

(3) by redesignating subsection (b) as subsection (c);

(4) by inserting the following new subsection immediately after subsection (a);

"(b) A Professional Standards Review Organization shall provide, in accordance with procedures established by the Secretary, data and information—

"(1) to assist Federal and State agencies recognized by the Secretary as having responsibility for identifying and investigating cases or patterns of fraud or abuse, which data and information shall be provided by such organization to such agencies at the request of such agencies at the discretion of such Organization on the basis of its findings with respect to evidence of fraud or abuse; and

"(2) to assist the Secretary, and such Federal and State agencies recognized by the Secretary as having health planning or related responsibilities under Federal or State law (including health systems agencies and State health planning and development agencies), in carrying out appropriate health care planning and related activities, which data and information shall be provided in such format and manner as may be prescribed by the Secretary or agreed upon by the responsible Federal and State agencies and such Organization, and shall be in the form of aggregate statistical data (without identifying any individual) on a geographic, institutional, or other basis reflecting the volume and frequency of services furnished, as well as the demographic characteristics of the population subject to review by such Organization.

The penalty provided in subsection (c) shall not apply to the disclosure of any data and information received under this subsection, except that such penalty shall apply to the disclosure (by the agency receiving such data and information) of any such data and information described in paragraph (1) unless such disclosure is made in a judicial, administrative, or other formal legal proceeding resulting from an investigation conducted by the agency receiving the data and information."; and

Patient records, nondisclosure.
42 USC 1320c-15.

(5) by inserting after subsection (c) (as so redesignated) the following new subsection:

"(d) No patient record in the possession of a Professional Standards Review Organization, a Statewide Professional Standards Review Council, or the National Professional Standards Review Council shall be subject to subpena or discovery proceedings in a civil action.".

Payment.
42 USC 1320c-16.

(i) Section 1167 of such Act is amended by adding the following new subsection at the end thereof:

"(d) The Secretary shall make payment to a Professional Standards Review Organization, whether conditionally designated or qualified, or to any member or employee thereof, or to any person who furnishes legal counsel or services to such organization, in an amount equal to the reasonable amount of the expenses incurred, as determined by the Secretary, in connection with the defense of any suit, action, or proceeding brought against such organization, member, or employee related to the performance of any duty or function of such organization, member, or employee (as described in section 1155).".

42 USC 1320c-4.
42 USC 1320c-17.

(j) Section 1168 of such Act is amended by adding at the end thereof the following new sentence: "The Secretary shall make payments to Professional Standards Review Organizations (whether designated on a conditional basis or otherwise) from funds described in the first sentence of this section (without any requirement for the contribution of funds by any State or political subdivision thereof) for expenses incurred in the performance of duties by such Orgnizations.".

Annual report to Congress.
Ante, p. 1186.

(k) Part B of title XI of such Act (as amended by subsection (d)(2)(D) of this section) is further amended by adding after section 1171 the following new section:

"ANNUAL REPORTS

42 USC 1320c-21.

"SEC. 1172. The Secretary shall submit to the Congress not later than April 1, 1978, and not later than April 1 of each year thereafter, a full and complete report on the administration, impact, and cost of the program under this part during the preceding fiscal year, including data and information on—

"(1) the number, status (conditional or otherwise), and service areas of, and review methodologies employed by, all Professional Standards Review Organizations participating in the program;

"(2) the number of health care institutions and practitioners whose services are subject to review by Professional Standards Review Organizations, and the number of beneficiaries and recipients who received services subject to such review during such year;

"(3) the imposition of penalties and sanctions under this title for violations of law and for failure to comply with the obligations imposed by this part;

42 USC 701, 1301, 1395, 1396.

"(4) the total costs incurred under titles V, XI, XVIII, and XIX of this Act in the implementation and operation of all procedures required by such titles for the review of services to determine their medical necessity, appropriateness of use, and quality;

"(5) changes in utilization rates and patterns, and changes in medical procedures and practices, attributable to the activities of Professional Standards Review Organizations;

"(6) the results of program evaluation activities, including the operation of data collection systems and the status of Professional Standards Review Organization data policy and implementation;

"(7) the extent to which Professional Standards Review Organizations are performing reviews of services for other governmental or private health insurance programs; and

"(8) recommendations for legislative changes.".

(l)(1) Title XI of such Act (as amended by subsections (d)(2)(D) and (k) of this section) is further amended by adding after section 1172 the following new section: *Ante*, p. 1190.

"MEDICAL OFFICERS IN AMERICAN SAMOA, THE NORTHERN MARIANA ISLANDS, AND THE TRUST TERRITORY OF THE PACIFIC ISLANDS TO BE INCLUDED IN THE PROFESSIONAL STANDARDS REVIEW PROGRAM

"SEC. 1173. For purposes of applying this part (except sections 1155(c) and 1163) to American Samoa, the Northern Mariana Islands, and the Trust Territory of the Pacific Islands, individuals licensed to practice medicine in those places shall be considered to be physicians and doctors of medicine.". 42 USC 1320c-22. 42 USC 1320c-4, 1320c-12.

(2) The second sentence of section 1101(a)(1) of such Act is amended by inserting "and in part B of this title" after "title V". 42 USC 1301.

(m) Section 1861(w)(2) of such Act is amended by inserting "part B of this title or under" immediately after "entitled to have payment made for such services under". 42 USC 1395x.

(n) Section 1167 of such Act is amended— 42 USC 1320c-16.

(1) by inserting "or to any Statewide Professional Standards Review Council" in subsection (a) after "Professional Standards Review Organization";

(2) by inserting "or such Council" in subsection (a) after "such Organization";

(3) by inserting "or of any Statewide Professional Standards Review Council" in subsection (b)(1) after "Professional Standards Review Organization";

(4) by inserting "or council" in subsection (b)(1) after "organization";

(5) by inserting "or of Statewide Professional Standards Review Councils" in subsection (b)(1) after "Review Organizations"; and

(6) by inserting "AND STATEWIDE PROFESSIONAL STANDARDS REVIEW COUNCILS" in the heading of the section after "PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS".

(o)(1) Section 1152(b)(1)(A) of such Act is amended by striking out "subsection (c)(i)" and inserting in lieu thereof "subsection (c)(1)". 42 USC 1320c-1.

(2) Section 1155(a)(1) of such Act is amended by striking out "(subject to the provisions of subsection (g))" in the matter preceding subparagraph (A). 42 USC 1320c-4.

(3) Section 1160(b)(1) of such Act is amended by inserting "or" after "permanently" in the matter following subparagraph (B). *Ante*, p. 1189.

42 USC 1320c-4.

(p) Section 1155(a)(5) of such Act is amended by striking out all that follows "Professional Standards Review Organization" and inserting in lieu thereof a period.

ISSUANCE OF SUBPENAS BY COMPTROLLER GENERAL

Ante, p. 1177.

SEC. 6. Part A of title XI of the Social Security Act is amended by inserting after section 1124 (added by section 3(a) of this Act) the following new section:

"ISSUANCE OF SUBPENAS BY COMPTROLLER GENERAL

42 USC 1320a-4.

"SEC. 1125. (a) For the purpose of any audit, investigation, examination, analysis, review, evaluation, or other function authorized by law with respect to any program authorized under this Act, the Comptroller General of the United States shall have power to sign and issue subpenas to any person requiring the production of any pertinent books, records, documents, or other information. Subpenas so issued by the Comptroller General shall be served by anyone authorized by him (1) by delivering a copy thereof to the person named therein, or (2) by registered mail or by certified mail addressed to such person at his last dwelling place or principal place of business. A verified return by the person so serving the subpena setting forth the manner of service, or, in the case of service by registered mail or by certified mail, the return post office receipt therefor signed by the person so served, shall be proof of service.

Noncompliance, penalty.
Representation.

5 USC 101 *et seq.*

5 USC 5101, 5331, 5361.

"(b) In case of contumacy by, or refusal to obey a subpena issued pursuant to subsection (a) of this section and duly served upon, any person, any district court of the United States for the judicial district in which such person charged with contumacy or refusal to obey is found or resides or transacts business, upon application by the Comptroller General, shall have jurisdiction to issue an order requiring such person to produce the books, records, documents, or other information sought by the subpena; and any failure to obey such order of the court may be punished by the court as a contempt thereof. In proceedings brought under this subsection, the Comptroller General shall be represented by attorneys employed in the General Accounting Office or by counsel whom he may employ without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and the provisions of chapter 51 and subchapters III and VI of chapter 53 of such title, relating to classification and General Schedule pay rates.

Personal medical records, nondisclosure.

"(c) No personal medical record in the possession of the General Accounting Office shall be subject to subpena or discovery proceedings in a civil action.".

SUSPENSION OF PRACTITIONERS CONVICTED OF MEDICARE- OR MEDICAID-RELATED CRIMES

42 USC 1395y.

SEC. 7. (a) Section 1862 of the Social Security Act is amended by adding at the end thereof the following new subsection:

42 USC 1396.

"(e)(1) Whenever the Secretary determines that a physician or other individual practitioner has been convicted (on or after the date of the enactment of this subsection, or within such period prior to that date as the Secretary shall specify in regulations) of a criminal offense related to such physician's or practitioner's involvement in the programs under this title or the program under title XIX, the Secretary shall suspend such physician or practitioner from participation in the program under this title for such period as he may deem appropriate; and no payment may be made under this title with respect to any item or service furnished by such physician or practitioner during the period of such suspension. The provisions of paragraphs (2) and (3) of subsection (d) shall apply with respect to determinations made by the Secretary under this subsection.

Notification of State or local agencies.

"(2) In any case where the Secretary under paragraph (1) suspends any physician or other individual practitioner from participation in the program under this title, he shall—

"(A) promptly notify each single State agency which administers or supervises the administration of a State plan approved under title XIX of the fact, circumstances, and period of such suspension; and

42 USC 1396.

"(B) promptly notify the appropriate State or local agency or authority having responsibility for the licensing or certification of such physician or practitioner of the fact and circumstances of such suspension, request that appropriate investigations be made and sanctions invoked in accordance with applicable State law and policy, and request that such State or local agency or authority keep the Secretary and the Inspector General of the Department of Health, Education, and Welfare fully and currently informed with respect to any actions taken in response to such request.".

(b) Section 1902(a) of such Act (as amended by section 2(b) and 3(c) of this Act) is amended—

***Ante*, p. 1178.**

(1) by striking out "and" at the end of paragraph (37);

(2) by striking out the period at the end of paragraph (38) and inserting in lieu thereof "; and"; and

(3) by inserting after paragraph (38) the following new paragraph:

"(39) provide that, subject to subsection (g), whenever the single State agency which administers or supervises the administration of the State plan is notified by the Secretary under section 1862(e)(2)(A) that a physician or other individual practitioner has been suspended from participation in the program under title XVIII, the agency shall promptly suspend such physician or practitioner from participation in the plan for not less than the period specified in such notice, and no payment may be made under the plan with respect to any item or service furnished by such physician or practitioner during the period of the suspension under this title.".

Supra.

42 USC 1395.

Suspension, waiver.

Supra.

(c) Section 1902 of such Act is amended by adding after subsection (f) the following new subsection:

"(g) The Secretary may waive suspension under subsection (a)(39) of a physician's or practitioner's participation in a State plan approved under this title and of the prohibition under such subsection of payment for any item or service furnished by him during the period of such suspension, if the single State agency which administers or supervises the administration of the plan submits a request to the Secretary for such waiver and if the Secretary approves such request.".

42 USC 254e.

(d) Section 332(c) of the Public Health Service Act (relating to considerations in the designation of health manpower shortage areas) is amended by inserting after paragraph (2) the following new paragraph:

"(3) The extent to which individuals who are (A) residents of the area, members of the population group, or patients in the medical facility or other public facility under consideration for designation, and (B) entitled to have payment made for medical services under title XVIII or XIX of the Social Security Act, cannot obtain such services because of suspension of physicians from the programs under such titles.".

42 USC 1395, 1396.

Effective dates. 42 USC 254e note.

(e)(1) The amendment made by subsection (d) shall apply with respect to determinations and designations made on and after the date of the enactment of this Act.

42 USC 1396a note.

(2) The amendment made by subsection (b) shall become effective on January 1, 1978.

DISCLOSURE BY PROVIDERS OF OWNERS AND CERTAIN OTHER INDIVIDUALS CONVICTED OF CERTAIN OFFENSES

Ante, p. 1192.

Sec. 8. (a) Part A of title XI of the Social Security Act is amended by inserting after section 1125 (added by section 6 of this Act) the following new section:

"DISCLOSURE BY INSTITUTIONS, ORGANIZATIONS, AND AGENCIES OF OWNERS AND CERTAIN OTHER INDIVIDUALS WHO HAVE BEEN CONVICTED OF CERTAIN OFFENSES

42 USC 1320a-5.

42 USC 1395, 1396, 1397.

"Sec. 1126. (a) As a condition of participation in or certification or recertification under the programs established by titles XVIII, XIX, and XX, any hospital, nursing facility, or other institution, organization, or agency shall be required to disclose to the Secretary or to the appropriate State agency the name of any person who—

"(1) has a direct or indirect ownership or control interest of 5 percent or more in such institution, organization, or agency or is an officer, director, agent, or managing employee (as defined in subsection (b)) of such institution, organization, or agency, and

"(2) has been convicted (on or after the date of the enactment of this section, or within such period prior to that date as the Secretary shall specify in regulations) of a criminal offense related to the involvement of such person in any of such programs.

The Secretary or the appropriate State agency shall promptly notify the Inspector General in the Department of Health, Education, and Welfare of the receipt from any institution, organization, or agency of any application or request for such participation, certification, or recertification which discloses the name of any such person, and shall notify the Inspector General of the action taken with respect to such application or request.

"Managing" employee.

"(b) For the purposes of this section, the term 'managing employee' means, with respect to an institution, organization, or agency, an individual, including a general manager, business manager, administrator, and director, who exercises operational or managerial control over the institution, organization, or agency, or who directly or indirectly conducts the day-to-day operations of the institution, organization, or agency.".

42 USC 1395cc.

(b)(1) Section 1866(a) of such Act is amended by adding at the end thereof the following new paragraph:

"(3) The Secretary may refuse to enter into or renew an agreement under this section with a provider of services if any person who has a direct or indirect ownership or control interest of 5 percent or more in such provider, or who is an officer, director, agent, or managing employee (as defined in section 1126(b)) of such provider, is a person described in section 1126(a).".

Ante, p. 1194.

(2) Section 1866(b)(2) of such Act is amended by inserting before the period at the end thereof the following: ", or (G) that such provider (at the time the agreement was entered into) did not fully and accurately make any disclosure required of it by section 1126(a)".

42 USC 1395cc.

(c) Section 1903 of such Act is amended by adding after subsection (m) the following new subsection:

42 USC 1396b.

"(n) The State agency may refuse to enter into any contract or agreement with a hospital, nursing home, or other institution, organization, or agency for purposes of participation under the State plan, or otherwise to approve an institution, organization, or agency for such purposes, if any person, who has a direct or indirect ownership or control interest of 5 percent or more in such institution, organization, or agency, or who is an officer, director, agent, or managing employee (as defined in section 1126(b)) of such institution, organization, or agency, is a person described in section 1126(a) (whether or not such institution, organization, or agency has in effect an agreement entered into with the Secretary pursuant to section 1866 or is subject to a suspension of payment order issued under subsection (j) of this section); and, notwithstanding any other provision of this section, the State agency may terminate any such contract, agreement, or approval if it determines that the institution, organization, or agency did not fully and accurately make any disclosure required of it by section 1126(a) at the time such contract or agreement was entered into or such approval was given.".

Ante, p. 1194.

Supra.

(d) Section 2002(a) of such Act (as amended by section 3(d) of this Act) is further amended by adding at the end thereof the following new paragraph:

Ante, p. 1179.

"(16) Any State may refuse to enter into a contract or other arrangement with a provider of services for purposes of participation under the program established by this title, or otherwise to approve a provider for such purposes, if any person who has a direct or indirect ownership or control interest of 5 percent or more in such provider, or who is an officer, director, agent, or managing employee (as defined in section 1126(b)) of such provider, is a person described in section 1126(a), and the State may terminate any such contract, arrangement, or approval if it determines that the provider did not fully and accurately make any disclosure required of it by section 1126(a) at the time the contract or arrangement was entered into or the approval was given.".

Ante, p. 1194.

(e) The amendments made by this section shall apply with respect to contracts, agreements, and arrangements entered into and approvals given pursuant to applications or requests made on and after the first day of the fourth month beginning after the date of the enactment of this Act.

Effective date.
42 USC 1320a–5 note.

FEDERAL ACCESS TO RECORDS

SEC. 9. Section 1902(a)(27)(B) of the Social Security Act is amended by inserting "or the Secretary" after "State agency" each place it appears.

42 USC 1396a.

CLAIMS PROCESSING AND INFORMATION RETRIEVAL SYSTEMS FOR MEDICAID PROGRAMS

SEC. 10. (a) Section 1903(a)(3)(B) of the Social Security Act is amended by striking out "notice to each individual who is furnished services covered by the plan of the specific services so covered" and

42 USC 1396b.

inserting in lieu thereof "notice to each individual who is furnished services covered by the plan, or to each individual in a sample group of individuals who are furnished such services, of the specific services (other than confidential services) so covered".

Effective date.
42 USC 1396b note.

(b) The amendment made by subsection (a) shall apply with respect to calendar quarters beginning after the date of the enactment of this Act.

RESTRICTION ON FEDERAL MEDICAID PAYMENTS; ASSIGNMENT OF RIGHTS OF PAYMENT; INCENTIVE PAYMENTS

Ante, p. 1195.

SEC. 11. (a) Section 1903 of the Social Security Act is amended by adding after subsection (n) (added by section 8(c) of this Act) the following new subsections:

"(o) Notwithstanding the preceding provisions of this section, no payment shall be made to a State under the preceding provisions of this section for expenditures for medical assistance provided for an individual under its State plan approved under this title to the extent that a private insurer (as defined by the Secretary by regulation) would have been obligated to provide such assistance but for a provision of its insurance contract which has the effect of limiting or excluding such obligation because the individual is eligible for or is provided medical assistance under the plan.

Infra.

"(p)(1) When a political subdivision of a State makes, for the State of which it is a political subdivision, or one State makes, for another State, the enforcement and collection of rights of support or payment assigned under section 1912, pursuant to a cooperative arrangement under such section (either within or outside of such State), there shall be paid to such political subdivision or such other State from amounts which would otherwise represent the Federal share of payments for medical assistance provided to the eligible individuals on whose behalf such enforcement and collection was made, an amount equal to 15 percent of any amount collected which is attributable to such rights of support or payment.

"(2) Where more than one jurisdiction is involved in such enforcement or collection, the amount of the incentive payment determined under paragraph (1) shall be allocated among the jurisdictions in a manner to be prescribed by the Secretary.".

42 USC 1396.

(b) Title XIX of the Social Security Act is amended by adding at the end thereof the following new section:

"ASSIGNMENT OF RIGHTS OF PAYMENT

42 USC 1396k.

"SEC. 1912. (a) For the purpose of assisting in the collection of medical support payments and other payments for medical care owed to recipients of medical assistance under the State plan approved under this title, a State plan for medical assistance may—

"(1) provide that, as a condition of eligibility for medical assistance under the State plan to an individual who has the legal capacity to execute an assignment for himself, the individual is required—

"(A) to assign the State any rights, of the individual or of any other person who is eligible for medical assistance under this title and on whose behalf the individual has the legal authority to execute an assignment of such rights, to support (specified as support for the purpose of medical care by a court or administrative order) and to payment for medical care from any third party; and

"(B) to cooperate with the State (i) in establishing the paternity of such person (referred to in subparagraph (A)) if the person is a child born out of wedlock, and (ii) in obtaining support and payments (described in subparagraph (A)) for himself and for such person, unless (in either case) the individual is found to have good cause for refusing to cooperate as determined by the State agency in accordance with standards prescribed by the Secretary, which standards shall take into consideration the best interests of the individuals involved; and

Cooperative arrangements with State agencies.

"(2) provide for entering into cooperative arrangements (including financial arrangements), with any appropriate agency of any State (including, with respect to the enforcement and collection of rights of payment for medical care by or through a parent, with a State's agency established or designated under section 454(3)) and with appropriate courts and law enforcement officials, to assist the agency or agencies administering the State plan with respect to (A) the enforcement and collection of rights to support or payment assigned under this section and (B) any other matters of common concern.

42 USC 654.

Retainages.

"(b) Such part of any amount collected by the State under an assignment made under the provisions of this section shall be retained by the State as is necessary to reimburse it for medical assistance payments made on behalf of an individual with respect to whom such assignment was executed (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing of such medical assistance), and the remainder of such amount collected shall be paid to such individual.".

Effective date. 42 USC 1396b note. 42 USC 1396.

(c) The amendment made by subsection (a) shall apply with respect to medical assistance provided, under a State plan approved under title XIX of the Social Security Act, on and after January 1, 1978.

STUDY AND REVIEW OF MEDICARE CLAIMS PROCESSING

42 USC 1395*ll* note.

42 USC 1395.

Sec. 12. The Comptroller General of the United States shall conduct a comprehensive study and review of the administrative structure established for the processing of claims under title XVIII of the Social Security Act, for the purpose of determining whether and to what extent more efficient claims administration under such title could be achieved—

(1) by reducing the number of participating intermediaries and carriers;

(2) by making a single organization responsible for the processing of claims, under both part A and part B of such title, in a particular geographic area;

(3) by providing for the performance of claims processing functions on the basis of a prospective fixed price;

(4) by providing incentive payments for the most efficient organizations; or

(5) by other modifications in such structure and related procedures.

Report to Congress.

The Comptroller General shall submit to the Congress no later than July 1, 1979, a complete report setting forth the results of such study and review, together with his findings and his recommendations with respect thereto.

ABOLITION OF PROGRAM REVIEW TEAMS UNDER MEDICARE

42 USC 1395y.

Sec. 13. (a) Section 1862(d) of the Social Security Act is amended by striking out paragraph (4).

42 USC 1395y.

(b) (1) Section 1862(d)(1)(B) of such Act is amended by striking out ", with the concurrence of the appropriate program review team appointed pursuant to paragraph (4),".

(2) Section 1862(d)(1)(C) of such Act is amended to read as follows:

"(C) has furnished services or supplies which are determined by the Secretary, on the basis of reports transmitted to him in accordance with section 1157 of this Act (or, in the absence of any such report, on the basis of such data as he acquires in the administration of the program under this title), to be substantially in excess of the needs of individuals or to be of a quality which fails to meet professionally recognized standards of health care.".

42 USC 1320c-6.

42 USC 1395cc.

(3) Clause (F) of section 1866(b)(2) of such Act is amended to read as follows: "(F) that such provider has furnished services or supplies which are determined by the Secretary to be substantially in excess of the needs of individuals or to be of a quality which fails to meet professionally recognized standards of health care.".

42 USC 1320c-6.

(4) Section 1157 of such Act is amended by striking out the last sentence.

Effective date.
42 USC 1320c-6 note.

(c) The amendments made by this section shall take effect on the date of the enactment of this Act.

AMENDMENTS RELATING TO FISCAL INTERMEDIARIES

42 USC 1395h.

Sec. 14. (a) Section 1816 of the Social Security Act is amended—

(1) by inserting "(and to providers assigned to such agency or organization under subsection (e))" in the first sentence of subsection (a) after "to such providers" the second and third times it appears;

Agreements.

(2) by amending subsection (b) to read as follows:

"(b) The Secretary shall not enter into or renew an agreement with any agency or organization under this section unless—

"(1) he finds—

Infra.

"(A) after applying the standards, criteria, and procedures developed under subsection (f), that to do so is consistent with the effective and efficient administration of this part, and

"(B) that such agency or organization is willing and able to assist the providers to which payments are made through it under this part in the application of safeguards against unnecessary utilization of services furnished by them to individuals entitled to hospital insurance benefits under section 226, and the agreement provides for such assistance; and

42 USC 426.
Information, availability.

"(2) such agency or organization agrees—

"(A) to furnish to the Secretary such of the information acquired by it in carrying out its agreement under this section, and

"(B) to provide the Secretary with access to all such data, information, and claims processing operations,

as the Secretary may find necessary in performing his functions under this part.";

Infra.

(3) by inserting "after applying the standards, criteria, and procedures developed under subsection (f) and" in subsection (e)(2) before "after reasonable notice";

(4) by redesignating subsections (e), (f), and (g) as subsections (g), (h), and (i), respectively; and

(5) by inserting after subsection (d) the following new subsections:

42 USC 1395h.

"(e)(1) Notwithstanding subsections (a) and (d), the Secretary, after taking into consideration any preferences of providers of services, may assign or reassign any provider of services to any agency or organization which has entered into an agreement with him under this section, if he determines, after applying the standards, criteria, and procedures developed under subsection (f), that such assignment or reassignment would result in the more effective and efficient administration of this part.

"(2) Notwithstanding subsections (a) and (d), the Secretary may designate a national or regional agency or organization which has entered into an agreement with him under this section to perform functions under the agreement with respect to a class of providers of services in the Nation or region (as the case may be), if he determines, after applying the standards, criteria, and procedures developed under subsection (f), that such designation would result in more effective and efficient administration of this part.

"(3)(A) Before the Secretary makes an assignment or reassignment under paragraph (1) of a provider of services to other than the agency or organization nominated by the provider, he shall furnish (i) the provider and such agency or organization with a full explanation of the reasons for his determination as to the efficiency and effectiveness of the agency or organization to perform the functions required under this part with respect to the provider, and (ii) such agency or organization with opportunity for a hearing, and such determination shall be subject to judicial review in accordance with chapter 7 of title 5, United States Code.

Hearing.

5 USC 701.

"(B) Before the Secretary makes a designation under paragraph (2) with respect to a class of providers of services, he shall furnish (i) such providers and the agencies and organizations adversely affected by such designation with a full explanation of the reasons for his determination as to the efficiency and effectiveness of such agencies and organizations to perform the functions required under this part with respect to such providers, and (ii) the agencies and organizations adversely affected by such designation with opportunity for a hearing, and such determination shall be subject to judicial review in accordance with chapter 7 of title 5, United States Code.

Hearing.

"(f) In order to determine whether the Secretary should enter into, renew, or terminate an agreement under this section with an agency or organization, whether the Secretary should assign or reassign a provider of services to an agency or organization, and whether the Secretary should designate an agency or organization to perform services with respect to a class of providers of services, the Secretary shall develop standards, criteria, and procedures to evaluate such agency's or organization's (1) overall performance of claims processing and other related functions required to be performed by such an agency or organization under an agreement entered into under this section, and (2) performance of such functions with respect to specific providers of services, and the Secretary shall establish, by regulation, standards and criteria with respect to the efficient and effective administration of this part. No agency or organization shall be found under such standards and criteria not to be efficient or effective or to be less efficient or effective solely on the ground that the agency or organization serves only providers located in a single State.".

Standards, development.

42 USC 1395h note.
Ante, p. 1198.

(b) The Secretary of Health, Education, and Welfare shall develop the standards, criteria, and procedures described in subsection (f) of section 1816 of the Social Security Act (as added by subsection (a)(5)) not later than October 1, 1978.

Effective dates.
42 USC 1395h note.

(c) The amendment made by paragraphs (2) and (3) of subsection (a) to the extent that they require application of standards, criteria, and procedures developed under section 1816(f) of the Social Security Act shall apply to the entering into, renewal, or termination of agreements on and after October 1, 1978.

(d) Except as provided in subsection (c), the amendment made by subsection (a)(2) shall apply to agreements entered into or renewed on or after the date of enactment of this Act.

DISCLOSURE BY PROVIDERS OF THE HIRING OF CERTAIN FORMER EMPLOYEES OF FISCAL INTERMEDIARIES

Agreements.
42 USC 1395cc.

SEC. 15. (a) Section 1866(a)(1) of the Social Security Act is amended—

(1) by striking out the period at the end of subparagraph (C) and inserting in lieu thereof ", and"; and

Notification to Secretary.

(2) by inserting after subparagraph (C) the following new subparagraph:

"(D) to promptly notify the Secretary of its employment of an individual who, at any time during the year preceding such employment, was employed in a managerial, accounting, auditing, or similar capacity (as determined by the Secretary by regulation) by an agency or organization which serves as a fiscal intermediary or carrier (for purposes of part A or part B, or both, of this title) with respect to the provider.".

Effective date.
42 USC 1395cc note.

(b) The amendments made by subsection (a) shall apply with respect to agreements entered into or renewed on and after the date of enactment of this Act.

PAYMENT FOR DURABLE MEDICAL EQUIPMENT

42 USC 1395*l*.

SEC. 16. (a) Section 1833(f) of the Social Security Act is amended to read as follows:

"(f)(1) In the case of durable medical equipment to be furnished an individual as described in section 1861(s)(6), the Secretary shall determine, on the basis of such medical and other evidence as he finds appropriate (including certification by the attending physician with respect to expected duration of need), whether the expected duration of the medical need for the equipment warrants a presumption that purchase of the equipment would be less costly or more practical than rental. If the Secretary determines that such a presumption does exist, he shall require that the equipment be purchased, on a lease-purchase basis or otherwise, and shall make payment in accordance with the lease-purchase agreement (or in a lump sum amount if the equipment is purchased other than on a lease-purchase basis); except that the Secretary may authorize the rental of the equipment notwithstanding such determination if he determines that the purchase of the equipment would be inconsistent with the purposes of this title or would create an undue financial hardship on the individual who will use it.

Used equipment, coinsurance waiver.

"(2) With respect to purchases of used durable medical equipment, the Secretary may waive the 20 percent coinsurance amount applicable under subsection (a) whenever the purchase price of the used equipment is at least 25 percent less than the reasonable charge for comparable new equipment.

Reimbursement procedures.

"(3) For purposes of paragraph (1), the Secretary may, pursuant to agreements made with suppliers of durable medical equipment, establish reimbursement procedures which he finds to be equitable, economical, and feasible.

"(4) The Secretary shall encourage suppliers of durable medical equipment to make their equipment available to individuals entitled to benefits under this title on a lease-purchase basis whenever possible.".

Effective date.
42 USC 1395l note.

(b) The amendment made by subsection (a) shall apply with respect to durable medical equipment purchased or rented on or after October 1, 1977.

FUNDING OF STATE MEDICAID FRAUD CONTROL UNITS

42 USC 1396b.

Sec. 17. (a) Section 1903(a) of the Social Security Act is amended by redesignating paragraph (6) as paragraph (7) and by inserting after paragraph (5) the following new paragraph:

"(6) subject to subsection (b)(3), an amount equal to 90 per centum of the sums expended during each quarter beginning on or after October 1, 1977, and ending before October 1, 1980, with respect to costs incurred during such quarter (as found necessary by the Secretary for the elimination of fraud in the provision and administration of medical assistance provided under the State plan) which are attributable to the establishment and operation of (including the training of personnel employed by) a State medicaid fraud control unit (described in subsection (q)); plus".

(b) Section 1903(b) of such Act is amended by inserting after paragraph (2) the following new paragraph:

"(3) The amount of funds which the Secretary is otherwise obligated to pay a State during a quarter under subsection (a)(6) may not exceed the higher of—

"(A) $125,000, or

"(B) one-quarter of 1 per centum of the sums expended by the Federal, State, and local governments during the previous quarter in carrying out the State's plan under this title.".

"State medicaid fraud control unit."

(c) Section 1903 of such Act is further amended by inserting after subsection (p) (added by section 11(a) of this Act) the following new subsection:

Certification requirements.

"(q) For the purposes of this section, the term 'State medicaid fraud control unit' means a single identifiable entity of the State government which the Secretary certifies (and annually recertifies) as meeting the following requirements:

"(1) The entity (A) is a unit of the office of the State Attorney General or of another department of State government which possesses statewide authority to prosecute individuals for criminal violations, (B) is in a State the constitution of which does not provide for the criminal prosecution of individuals by a statewide authority and has formal procedures, approved by the Secretary, that (i) assure its referral of suspected criminal violations relating to the program under this title to the appropriate authority or authorities in the State for prosecution and (ii) assure its assistance of, and coordination with, such authority or authorities in such prosecutions, or (C) has a formal working relationship with the office of the State Attorney General and has formal procedures (including procedures for its referral of suspected criminal violations to such office) which are approved by the Secretary and which provide effective coordination of activities between the entity and such office with respect to the detection, investigation, and prosecution of suspected criminal violations relating to the program under this title.

"(2) The entity is separate and distinct from the single State agency that administers or supervises the administration of the State plan under this title.

"(3) The entity's function is conducting a statewide program for the investigation and prosecution of violations of all applicable State laws regarding any and all aspects of fraud in connection with any aspect of the provision of medical assistance and the activities of providers of such assistance under the State plan under this title.

"(4) The entity has procedures for reviewing complaints of the abuse and neglect of patients of health care facilities which receive payments under the State plan under this title, and, where appropriate, for acting upon such complaints under the criminal laws of the State or for referring them to other State agencies for action.

"(5) The entity provides for the collection, or referral for collection to a single State agency, of overpayments that are made under the State plan to health care facilities and that are discovered by the entity in carrying out its activities.

"(6) The entity employs such auditors, attorneys, investigators, and other necessary personnel and is organized in such a manner as is necessary to promote the effective and efficient conduct of the entity's activities.

Application and annual reports, submittal to Secretary.

"(7) The entity submits to the Secretary an application and annual reports containing such information as the Secretary determines, by regulation, to be necessary to determine whether the entity meets the other requirements of this subsection.".

42 USC 1395b-1.

(d) Section 402(a)(1) of the Social Security Amendments of 1967 (Public Law 90-248), as amended by section 222 of the Social Security Amendments of 1972 (Public Law 92-603), is amended—

(1) by striking out "and" at the end of subparagraph (H);

(2) by striking out the period at the end of subparagraph (I) and inserting in lieu thereof "; and"; and

(3) by adding after subparagraph (I) the following new subparagraph:

"(J) to develop or demonstrate improved methods for the investigation and prosecution of fraud in the provision of care or services under the health programs established by the Social Security Act.".

42 USC 1305.
Effective date.
42 USC 1396b note.
Regulations.

(e)(1) The amendment made by subsection (a) shall apply with respect to calendar quarters beginning after September 30, 1977.

(2) The Secretary of Health, Education, and Welfare shall establish such regulations, not later than ninety days after the date of enactment of this Act, as are necessary to carry out the amendments made by this section.

REPORT ON HOME HEALTH AND OTHER IN-HOME SERVICES

Report to congressional committees.
42 USC 1395ll note.

SEC. 18. (a) Not later than one year after the date of enactment of this Act, the Secretary of Health, Education, and Welfare shall submit to the appropriate committees of the Congress a report analyzing, evaluating, and making recommendations with respect to, all aspects (including the availability, administration, provision, reimbursement procedures, and cost) of the delivery of home health and other in-home services authorized to be provided under titles XVIII, XIX, and XX of the Social Security Act.

42 USC 1395, 1396, 1397.
Evaluation.
Legislative recommendations.

(b) Such report shall include an evaluation of the coordination of such services provided under the different titles, and shall also include recommendations for changes in regulations and legislation with respect to—

(1) the scope and definition of such services provided under such titles;

(2) the requirements for an individual to be eligible to receive such services under such titles;

(3) the standards for certification of providers of such services under such titles and (as appropriate) the uniformity of such standards for the programs under the different titles;

(4) procedures for control of utilization and assurance of quality of such services under such titles, including (as appropriate) the licensing and accreditation of agencies providing such services, a certificate of need program with respect to the offering of such services, and the development and use of norms and standards for review of the utilization and quality of such services;

(5) methods of reimbursement for such services, including (A) methods of comparing costs incurred by different providers of such services in order to determine the reasonableness of such costs and (B) methods which provide for more uniform reimbursement procedures under titles XVIII and XIX of the Social Security Act; and

(6) the prevention of fraud and abuse in the delivery of such services under such titles,

the reasons for such recommendations, an analysis of the impact of implementing such recommendations on the cost of such services and the demand for such services, and the methods of financing any recommended increased provision of such services under such titles.

Consultation.

(c) In developing the report the Secretary shall consult with professional organizations, experts, and individual health professionals in the field of home health and other in-home services and with providers, private insurers, and consumers of such services.

ESTABLISHMENT OF UNIFORM REPORTING SYSTEMS FOR DIFFERENT TYPES OF HEALTH SERVICES FACILITIES AND ORGANIZATIONS; MAKING OF REPORTS UNDER MEDICARE AND MEDICAID PROGRAMS IN ACCORDANCE WITH SUCH SYSTEMS

SEC. 19. (a) Part A of title XI of this Social Security Act is amended by inserting after section 1120 the following new section:

"UNIFORM REPORTING SYSTEMS FOR HEALTH SERVICES FACILITIES AND ORGANIZATIONS

Establishment, regulations.
42 USC 1320a.

"SEC. 1121. (a) For the purposes of reporting the cost of services provided by, of planning, and of measuring and comparing the efficiency of and effective use of services in, hospitals, skilled nursing facilities, intermediate care facilities, home health agencies, health maintenance organizations, and other types of health services facilities and organizations to which payment may be made under this Act, the Secretary shall establish by regulation, for each such type of health services facility or organization, a uniform system for the reporting by a facility or organization of that type of the following information:

"(1) The aggregate cost of operation and the aggregate volume of services.

"(2) The costs and volume of services for various functional accounts and subaccounts.

"(3) Rates, by category of patient and class of purchaser.

"(4) Capital assets, as defined by the Secretary, including (as appropriate) capital funds, debt service, lease agreements used in lieu of capital funds, and the value of land, facilities, and equipment.

"(5) Discharge and bill data.

42 USC 242k.

The uniform reporting system for a type of health services facility or organization shall provide for appropriate variation in the application of the system to different classes of facilities or organizations within that type and shall be established, to the extent practicable, consistent with the cooperative system for producing comparable and uniform health information and statistics described in section 306(e)(1) of the Public Health Service Act. In reporting under such a system, hospitals shall employ such chart of accounts, definitions, principles, and statistics as the Secretary may prescribe in order to reach a uniform reconciliation of financial and statistical data for specified uniform reports to be provided to the Secretary.

Duties.

"(b) The Secretary shall—

"(1) monitor the operation of the systems established under subsection (a);

"(2) assist with and support demonstrations and evaluations of the effectiveness and cost of the operation of such systems and encourage State adoption of such systems; and

"(3) periodically revise such systems to improve their effectiveness and diminish their cost.

Information, availability.

42 USC 300*l*–4.

42 USC 300m.

"(c) The Secretary shall provide information obtained through use of the uniform reporting systems described in subsection (a) in a useful manner and format to appropriate agencies and organizations, including health systems agencies (designated under section 1515 of the Public Health Service Act) and State health planning and development agencies (designated under section 1521 of such Act), as may be necessary to carry out such agencies' and organizations' functions.".

42 USC 1395x.

(b)(1) Section 1861(v)(1) of the Social Security Act is amended by adding after subparagraph (E) the following new subparagraph:

Reports.

Ante, p. 1203.

"(F) Such regulations shall require each provider of services (other than a fund) to make reports to the Secretary of information described in section 1121(a) in accordance with the uniform reporting system (established under such section) for that type of provider.".

Ante, p. 1193.

(2) Section 1902(a) of such Act (as amended by sections 2(b), 3(c), and 7(b) of this Act) is amended—

(A) by striking out "and" at the end of paragraph (38);

(B) by striking out the period at the end of paragraph (39) and inserting in lieu thereof "; and"; and

(C) by inserting after paragraph (39) the following new paragraph:

Reports.

"(40) require each health services facility or organization which receives payments under the plan and of a type for which a uniform reporting system has been established under section 1121(a) to make reports to the Secretary of information described in such section in accordance with the uniform reporting system (established under such section) for that type of facility or organization.".

Consultation.
42 USC 1320a note.
Ante, p. 1203.

(c)(1) The Secretary of Health, Education, and Welfare shall establish the systems described in section 1121(a) of the Social Security Act (added by subsection (a) of this section) only after consultation with interested parties and—

(A) for hospitals, skilled nursing facilities, and intermediate care facilities, not later than the end of the one-year period, and

(B) for other types of health services facilities and organizations, not later than the end of the two-year period,

beginning on the date of enactment of this Act.

Effective dates.
42 USC 1396a note.

(2)(A) The amendments made by subsection (b) shall apply with respect to operations of a hospital, skilled nursing facility, or intermediate care facility, on and after the first day of its first fiscal year which begins after the end of the six-month period beginning on the date a uniform reporting system is established (under section 1121(a) of the Social Security Act) for that type of health services facility.

(B) The amendments made by subsection (b) shall apply, with respect to the operation of a health services facility or organization which is neither a hospital, a skilled nursing facility, nor an intermediate care facility, on and after the first day of its first fiscal year which begins after such date as the Secretary of Health, Education, and Welfare determines to be appropriate for the implementation of the reporting requirement for that type of facility or organization.

(C) Except as provided in subparagraphs (A) and (B), the amendments made by subsection (b)(2) shall apply, with respect to State plans approved under title XIX of the Social Security Act, on and after October 1, 1977. 42 USC 1396.

DELAY IN, AND WAIVER OF, IMPOSITION OF REDUCTION OF FEDERAL MEDICAL ASSISTANCE PERCENTAGE DUE TO A STATE'S FAILURE TO HAVE AN EFFECTIVE MEDICAID UTILIZATION CONTROL PROGRAM

SEC. 20. (a) Section 1903(g) of the Social Security Act is amended— 42 USC 1396b.

(1) by striking out "With respect to" in the first sentence of paragraph (1) and inserting in lieu thereof "Subject to paragraph (3), with respect to";

(2) by striking out "by 33⅓ per centum thereof" in paragraph (1) and inserting in lieu thereof "by a per centum thereof (determined under paragraph (5))";

(3) by inserting "timely" in paragraph (2) before "sample onsite surveys"; and

(4) by adding after paragraph (2) the following new paragraphs:

"(3)(A) No reduction in the Federal medical assistance percentage of a State otherwise required to be imposed under this subsection shall take effect—

"(i) if such reduction is due to the State's unsatisfactory or invalid showing made with respect to a calendar quarter beginning before January 1, 1977;

"(ii) before January 1, 1978;

Notice to States.

"(iii) unless a notice of such reduction has been provided to the State at least 30 days before the date such reduction takes effect; or

"(iv) due to the State's unsatisfactory or invalid showing made with respect to a calendar quarter beginning after September 30, 1977, unless notice of such reduction has been provided to the State no later than the first day of the fourth calendar quarter following the calendar quarter with respect to which such showing was made.

Waiver.

"(B) The Secretary shall waive application of any reduction in the Federal medical assistance percentage of a State otherwise required to be imposed under paragraph (1) because a showing by the State, made under such paragraph with respect to a calendar quarter ending after January 1, 1977, and before October 1, 1977, is determined to be either unsatisfactory under such paragraph or invalid under paragraph (2), if the Secretary determines that the State's showing made under paragraph (1) with respect to the calendar quarter ending on December 31, 1977, is satisfactory under such paragraph and is valid under paragraph (2).

"(4)(A) The Secretary may not find the showing of a State, with respect to a calendar quarter under paragraph (1), to be satisfactory if the showing is submitted to the Secretary later than the 30th day after the last day of the calendar quarter, unless the State demonstrates to the satisfaction of the Secretary good cause for not meeting such deadline.

"(B) The Secretary shall find a showing of a State, with respect to a calendar quarter under paragraph (1), to be satisfactory under such paragraph with respect to the requirement that the State conduct annual onsite inspections in mental hospitals, skilled nursing facilities, and intermediate care facilities under paragraph (26) and (31) of section 1902(a), if the showing demonstrates that the State has conducted such an onsite inspection during the 12-month period ending on the last date of the calendar quarter—

Post, p. 1207.
42 USC 1396a.

"(i) in each of not less than 98 per centum of the number of such hospitals and facilities requiring such inspection, and

"(ii) in every such hospital or facility which has 200 or more beds,

and that, with respect to such hospitals and facilities not inspected within such period, the State has exercised good faith and due diligence in attempting to conduct such inspection, or if the State demonstrates to the satisfaction of the Secretary that it would have made such a showing but for failings of a technical nature only.

"(5) In the case of a State's unsatisfactory or invalid showing made with respect to a type of facility or institutional services in a calendar quarter, the per centum amount of the reduction of the State's Federal medical assistance percentage for that type of services under paragraph (1) is equal to 33⅓ per centum multiplied by a fraction, the denominator of which is equal to the total number of patients receiving that type of services in that quarter under the State plan in facilities or institutions for which a showing was required to be made under this subsection, and the numerator of which is equal to the number of such patients receiving such type of services in that quarter in those facilities or institutions for which a satisfactory and valid showing was not made for that calendar quarter.

Report to Congress.

"(6) The Secretary shall submit to Congress, not later than sixty days after the end of such calendar quarter, a report on—

"(A) his determination as to whether or not each showing, made under paragraph (1) by a State with respect to the calendar quarter, has been found to be satisfactory under such paragraph;

"(B) his review (through onsite surveys and otherwise) under paragraph (2) of the validity of showings previously submitted by a State; and

"(C) any reduction in the Federal medical assistance percentage he has imposed on a State because of its submittal under paragraph (1) of an unsatisfactory or invalid showing.".

42 USC 1396a.

(b) Section 1902(a)(26) of the Social Security Act is amended by inserting after "social service personnel" the following: ", or, in the case of skilled nursing facilities, composed of physicians or registered nurses and other appropriate health and social service personnel".

Effective date. 42 USC 1396b note. Payments, adjustment. *Ante*, p. 1195.

(c)(1) Except as provided in paragraph (2), the amendments made by this section shall be effective on October 1, 1977, and the Secretary of Health, Education, and Welfare shall promptly adjust payments made to States under section 1903 of the Social Security Act to reflect the changes made by such amendments.

(2) The amount of any reduction in the Federal medical assistance percentage of a State, otherwise required to be imposed under section 1903(g)(1) of the Social Security Act because of an unsatisfactory or invalid showing made by the State with respect to a calendar quarter beginning on or after January 1, 1977, shall be determined under such section as amended by this section. Subparagraph (B) of paragraph (4) of section 1905(g) of such Act, as added by this section, shall apply to any showing made by a State under such section with respect to a calendar quarter beginning on or after January 1, 1977.

PROTECTION OF PATIENT FUNDS

Accounting system, establishment. 42 USC 1395x.

Sec. 21. (a) Section 1861(j) of the Social Security Act is amended by striking out "and" at the end of paragraph (13) and inserting immediately after such paragraph (13) the following new paragraph:

"(14) establishes and maintains a system that (A) assures a full and complete accounting of its patients' personal funds, and (B) includes the use of such separate account for such funds as will preclude any commingling of such funds with facility funds or with the funds of any person other than another such patient; and".

Costs, definition. 42 USC 1395x note.

42 USC 1395, 1396.

(b) The Secretary of Health, Education, and Welfare shall, by regulation, define those costs which may be charged to the personal funds of patients in skilled nursing facilities who are individuals receiving benefits under the provisions of title XVIII, or under a State plan approved under the provisions of title XIX, of the Social Security Act, and those costs which are to be included in the reasonable cost or reasonable charge for extended care services as determined under the provisions of title XVIII, or for skilled nursing and intermediate care facility services as determined under the provisions of title XIX, of such Act.

Effective date.

(c)(1) The amendments made by subsection (a) shall be effectiv on the first day of the first calendar quarter which begins more than six months after the date of enactment of this Act.

Regulations.

(2) The Secretary of Health, Education, and Welfare shall issue the regulations required under subsection (b) within ninety days after the date of enactment of this Act.

PAYMENT FOR INSTITUTIONAL CARE BEYOND DATE DETERMINED MEDICALLY NECESSARY

42 USC 1320c-7.
Ante, p. 1185.

SEC. 22. (a) Section 1158 of the Social Security Act is amended—

(1) by inserting "and subsection (d)" in subsection (a) after "section 1159"; and

(2) by adding after subsection (c) (as added by section 5(d)(1) of this Act) the following new subsection:

"(d) In any case in which a Professional Standards Review Organization disapproves (under subsection (a)) of inpatient hospital services or posthospital extended care services, payment may be made for such services furnished before the second day after the day on which the provider received notice of such disapproval, or, if such organization determines that more time is required in order to arrange postdischarge care, payment may be made for such services furnished before the fourth day after the day on which the provider received notice of such disapproval.".

Effective date.
42 USC 1320c-7 note.

(b) The amendments made by subsection (a) shall be effective on the date of enactment of this Act.

PAYMENT UNDER THE MEDICARE PROGRAM FOR CERTAIN HOSPITAL SERVICES PROVIDED IN VETERANS' ADMINISTRATION HOSPITALS

42 USC 1395f.

SEC. 23. (a) Section 1814(c) of the Social Security Act is amended by inserting "or subsection (j)" after "subsection (d)".

(b) Section 1814 of such Act is further amended by adding at the end thereof the following new subsection:

"Payment for Certain Hospital Services Provided in Veterans' Administration Hospitals

Ante, p. 1191.
42 USC 426.

"(j)(1) Payments shall also be made to any hospital operated by the Veterans' Administration for inpatient hospital services furnished in a calendar year by the hospital, or under arrangements (as defined in section 1861(w)) with it, to an individual entitled to hospital benefits under section 226 even though the hospital is a Federal provider of services if (A) the individual was not entitled to have the services furnished to him free of charge by the hospital, (B) the individual was admitted to the hospital in the reasonable belief on the part of the admitting authorities that the individual was a person who was entitled to have the services furnished to him free of charge, (C) the authorities of the hospital, in admitting the individual, and the individual, acted in good faith, and (D) the services were furnished during a period ending with the close of the day on which the authorities operating the hospital first became aware of the fact that the individual was not entitled to have the services furnished to him by the hospital free of charge, or (if later) ending with the first day on which it was medically feasible to remove the individual from the hospital by discharging him therefrom or transferring him to a hospital which has in effect an agreement under this title.

"(2) Payment for services described in paragraph (1) shall be in an amount equal to the charge imposed by the Veterans' Administration for such services, or (if less) the reasonable costs for such services (as estimated by the Secretary). Any such payment shall be made to the entity to which payment for the services involved would have been payable, if payment for such services had been made by the individual receiving the services involved (or by another private person acting on behalf of such individual).".

(c) The amendments made by this section shall apply to inpatient hospital services furnished on and after July 1, 1974.

Effective date.
42 USC 1395f note.

Approved October 25, 1977.

LEGISLATIVE HISTORY:

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  Sept. 30, considered and passed Senate, amended, in lieu of S. 143.
  Oct. 13, House and Senate agreed to conference report.
WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS, Vol. 13, No. 44:
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○

95th Congress
1st Session
HOUSE OF REPRESENTATIVES
Report 95-393
Part 1

MEDICARE-MEDICAID ANTIFRAUD AND ABUSE AMENDMENTS

REPORT

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

(including cost estimate of the Congressional Budget Office)

ON

H.R. 3

June 7, 1977.—Ordered to be printed

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95TH CONGRESS } HOUSE OF REPRESENTATIVES { REPT. 95-393
1st Session } { PART 1

MEDICARE-MEDICAID ANTI-FRAUD AND ABUSE AMENDMENTS

JUNE 7, 1977.—Ordered to be printed

MR. ULLMAN, from the Committee on Ways and Means, submitted the following

REPORT

[Including cost estimate of the Congressional Budget Office]

[To accompany H.R. 3 which on Jan. 4, 1977, was referred jointly to the Committee on Ways and Means and the Committee on Interstate and Foreign Commerce]

The Committee on Ways and Means, to whom was referred the bill (H.R. 3) to strengthen the capability of the Government to detect, prosecute, and punish fraudulent activities under the medicare and medicaid programs, and for other purposes, having considered the same, report favorably thereon with amendments and recommend that the bill as amended do pass.

The amendments are as follows:

1. On page 1, strike out line 5 and all that follows through line 7 on page 27 and insert in lieu thereof the following:

PROHIBITION AGAINST ASSIGNMENT BY PHYSICIANS AND OTHERS OF CLAIMS FOR SERVICES; CLAIMS PAYMENT PROCEDURES FOR MEDICAID PROGRAM

SEC. 2. (a)(1) Section 1842(b)(5) of the Social Security Act is amended by adding at the end thereof the following new sentence: "No payment which under the preceding sentence may be made directly to the physician or other person providing the service involved (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) shall be made to anyone else under a reassignment or power of attorney (except to an employer or facility as described in clause (A) or (B) of such sentence); but nothing in this subsection shall be construed (i) to prevent the making of such

4. The bill would encourage each State to establish an office separate from the medicaid program agency to prepare and prosecute cases of suspected fraud and abuse in the program by providing for 90 percent Federal matching funds for expenditures to establish and operate State medicaid fraud control units. (Section 17)

5. The bill also requires States to make provision in their State medicaid plan for claims payment procedures which ensure that 90 percent of the bills submitted by eligible noninstitutionally-based providers will be reimbursed within 30 days, and 99 percent within 60 days. The State would not be cited for noncompliance if the Secretary found the State was acting in good faith to achieve this goal. (Section 2)

6. The bill directs the Comptroller General to conduct a comprehensive review of the administrative structure for the processing of medicare claims. (Section 12)

7. The bill requires the Secretary of Health, Education, and Welfare to report to the Congress within 12 months after enactment of this legislation with an analysis and recommendations relating to all aspects (including the availability, administration, provision, reimbursement procedures and cost) of the delivery of home health services under medicare, medicaid and the title XX social services program. (Section 18)

TECHNICAL REVISION

1. Your committee's bill clarifies existing law to insure that a power of attorney cannot be used to circumvent the prohibition in existing law against the use of "factoring" arrangements in connection with the payment of provider claims by the medicare and medicaid programs. (Section 2)

2. The bill modifies the provisions of existing law related to the rental or purchase of durable medical equipment to mandate that the Secretary require the purchase of such equipment where purchase will be less costly than extended rental payments. (Section 16)

3. The bill increases individual state's incentives to adopt a computerized medicaid claims processing and information retrieval system by modifying one current requirement for higher Federal matching funds for the development and operation of this system. The bill would require such systems to provide explanation of benefits information to only a sample group of medicaid recipients rather than to each recipient as is currently required. (Section 10)

4. The bill would preclude Federal matching of State medicaid expenditures that result from State laws or contracts which exclude or limit insurance benefits because an individual is eligible for medicaid. (Section 11)

III. General Statement

EXPLANATION, JUSTIFICATION, AND COMPARISON WITH PRESENT LAW

Prohibition Against Assignment by Physicians and Others of Claims for Services; Claims Payment Procedures for Medicaid Program (Section 2)

Your Committee's bill would modify existing law to preclude the use of a power of attorney as a device to circumvent the existing ban on the use of "factoring" arrangements in connection with the payment of claims by the medicare and medicaid programs. The bill further requires State medicaid programs to provide for timely claims payment procedures and provides higher Federal matching funds for a three-year period to assist States with programs of educational and technical assistance to expedite the filing and payment of claims.

In 1972, the Congress took action to stop a practice under which some physicians and other persons providing services under medicare and medicaid reassigned their medicare and medicaid receivables to other organizations or groups. Under the conditions of these reassignments, the organizations or groups purchased the receivables for a percentage of their face value, submitted claims and received payments in their name. By 1972, it had become apparent that such reassignments were a significant source of incorrect and inflated claims for services paid by medicare and medicaid. In addition, cases of fraudulent billings by collection agencies and substantial overpayments to these so-called "factoring" agencies were also found.

Congress concluded that such arrangements were not in the best interest of the government or the beneficiaries served by the medicare and medicaid programs. The Social Security Amendments of 1972, Public Law 92-603, therefore, included a prohibition against the payment for covered services to anyone other than the patient, his physician, or other person who provided the service, unless the physician or other person is required as a condition of his employment to turn his fees over to his employer, or unless the physician or other person has an arrangement with a facility under which the facility bills for such services.

Despite these efforts to stop factoring of medicare and medicaid bills, some practitioners and other persons have circumvented the intent of the law by use of a power of attorney. The use of a power of attorney allows the factoring company to receive the medicare or medicaid payment in the name of the physician, thus allowing the continuation of program abuses which factoring activities were shown to produce in the past.

Your committee's bill would modify existing law to preclude the use of a power of attorney as a device for reassignments of benefits under medicare and medicaid, other than an assignment to a governmental entity or establishment, or an assignment established by or pursuant to the order of a court of competent jurisdiction. The bill also provides for similar prohibitions with respect to billings for care provided by institutions under medicare and medicaid. However, it would not preclude the agent of a physician or other person furnishing services from collecting any medicare or medicaid payment on behalf of a physician, provided the agency does so pursuant to an agreement under which the compensation paid the agency for his services or for the billings or collections of payments is unrelated (directly or indirectly) to the dollar amount of the billings or payments, and is not dependent upon the actual collection of any such payments. Thus, the use of billing agents by doctors and others, when the agents are paid on a basis related to the cost of doing business and not dollar amounts billed or collected, would not be precluded. The bill would not impose any limitations on the use of billing or collection agencies for payments owed by anyone other than the medicare or medicaid programs. Nor is it your committee's intention that this provision preclude the legitimate transfer of accounts receivable from these programs by an individual or an institution upon the "sale" of the individual's practice (for example upon retirement) or as part of the sale of all the assets of an institution.

Your committee received considerable testimony indicating that undue delay in medicaid claims payments contributes to the rise of factoring arrangements as well as discourages physicians from participating in the program. The committee wishes to assure that the ban on factoring arrangements will not impose an undue hardship on medicaid practitioners. The bill therefore requires State medicaid plans to provide for claims payment procedures which ensure that 90 percent of claims for services furnished by health care practitioners through individual or group practices or through shared health facilities are paid within 30 days of receipt; 99 percent of such claims must be paid within 60 days of receipt. State plans must further provide for procedures for prepayment and postpayment claims review. The bill permits the Secretary of Health, Education, and Welfare to waive this State plan requirement if he finds that a State has exercised good faith in trying to ensure timeliness and accuracy in its claims payment operation. Among other things the Secretary should take into account in making a waiver determination is whether the State has received an unusually high volume of claims which are not clean claims (i.e., claims for which no further written information or substantiation is required from the provider).

In many areas of the country, a significant volume of medicaid claims submitted are inadequately or incorrectly filed. The bill therefore authorizes 90 percent Federal matching from January 1978 through September 1980 for the costs attributable to the conduct of such educational and technical assistance programs for health care practitioners as the Secretary determines are likely to expedite the filing and payment of claims. Technical assistance may be provided through such means, including outreach offices, the media, and telephone systems, as the Secretary determines to be appropriate. The maximum amount of payment available to the States under this section may not exceed $1.25 million in any calendar quarter. If the aggregate amount of payment would otherwise exceed this limitation, the amount made available to each State would be proportionately reduced.

Disclosure of Ownership and Financial Information (Section 3)

Your Committee's bill would require entities (other than individual practitioners or groups of practitioners) providing services under medicare, medicaid, or the maternal and child health program to disclose certain ownership interests, as a condition of program participation. These disclosure requirements would also be applied to medicare intermediaries and carriers and medicaid fiscal agents. Disclosure of additional ownership and financial information would be required, but only when specifically requested.

Current law and program policies already require the provision of certain ownership and financial information pertaining to entities providing services under medicare and medicaid. For example, an agreement with a provider of services under medicare may be terminated if the provider fails to furnish information necessary to validate the amount of payment claimed. In a different context, present law requires, as a medicare and medicaid condition of participation, a skilled nursing facility to disclose to the Secretary or appropriate State agency, and keep current, the name of anyone having significant ownership interest in the facility. Intermediate care facilities under medicaid are also required to disclose information on significant ownership interests.

Your Committee believes, however, that the information required under current law is often insufficient to facilitate the detection of fraudulent practices. Information now required does not provide adequate documentation on persons with significant ownership interests in more than one facility or other entity participating in medicare, medicaid, or the material and child health program. Information is not specifically required to identify persons with significant ownership interests in related companies that supply goods and services to providers or other participating entities. Authority to obtain information on financial transactions with related suppliers or with subcontractors is not clearly defined in law.

To remedy these problems, the bill would require disclosure of specified ownership information to the Secretary or the appropriate State agency, as a condition of an entity's participation, certification, or recertification under medicare, medicaid, or the maternal and child health program. Entities required to disclose would be defined as: Medicare providers of services (as defined in section 1861(u), which includes hospitals, skilled nursing facilities, and home health agencies), independent clinical laboratories, renal disease facilities, and all entities (other than individual practitioners or groups of practitioners) that claim reimbursement for services provided under medicaid or the maternal and child health program. In addition, the bill would require medicare intermediaries and carriers and medicaid fiscal agents to disclose specified ownership information as a condition of contract or agreement approval or renewal under titles XVIII and XIX.

The bill specifies that disclosing entities must supply full and complete information as to the identity of each person who:

(1) has a direct or indirect ownership interest of five percent or more in the entity,

(2) owns (in whole or part) a five percent interest in any mortgage secured by the entity,

(3) is an officer or director of the entity, if it is organized as a corporation, and

(4) is a partner in the entity, if it is organized as a partnership.

Where disclosing entities providing services under medicare or medicaid own five percent or more of a subcontractor, similar ownership information would be required to be disclosed about the subcontractor.

In addition, the bill would require, to the extent feasible, that information about a person's ownership disclosed by an entity must also include information with respect to ownership interest of that person in any other entity which is required to comply with disclosure requirements under the bill.

The bill would also modify the existing provisions of titles XVIII and XIX which relate to termination of medicare provider agreements or suspension of medicaid payments to health care entities (other than individual practitioners and groups of individual practitioners) by adding two additional requirements. The bill would require a provider entity to comply with specific requests addressed to it by the Secretary or the State medicaid agency for full and complete information on: (1) the ownership of any subcontractor (as defined in regulations) with whom the provider has annual business transactions of more than $25,000, and (2) any significant business transactions(as defined in regulations) between it and any subcontractor or between it and any wholly-owned supplier.

In developing regulations to define subcontractors and suppliers, the Committee intends that a distinction be made between agencies and organizations from which a provider only purchases goods and services to assist it in meeting its obligations to patients and those agencies and organizations to which a provider has actually delegated some of the duties and obligations it has directly to its patients. Although the facts and circumstances of individual situations may differ, it is contemplated under such a delineation that the relationship between a hospital and a commercial laundry would be considered to be that of a provider and its supplier, but that the relationship between a hospital and a management company with which it has contracted to administer either all or part of the day-to-day operations of the institution or the relationship between a hospital and an independent radiological service would be that of a provider and a subcontractor.

The bill specifies that the Secretary is to determine by regulation the meaning of the phrase "directly or indirectly" with respect to persons having ownership interests in disclosing entities. In directing him to do this, your Committee is acutely aware of the difficulties involved in developing this definition, particularly when the phrase "persons with ownership interests" is interpreted to mean a corporation. Institutional providers of health care often are owned by corporate entities which in turn are owned by other corporations. In order to compile accurate information on persons with ownership interests in disclosing entities, your Committee believes it is also necessary to obtain information on persons with ownership interests in these other corporations. The information to be disclosed under the bill must go beyond the listing of corporate identities unless that corporation is already subject to ownership disclosure under the statutes administered by the Securities and Exchange Commission or other Federal regulatory agencies. It is intended, at the minimum, to identify those persons with ownership interests of five percent or more in a nonpublicly held corporation that owns a disclosing entity. In addition, the Secretary may determine that it is necessary to require disclosure of persons with ownership interests in nonpublicly held corporations beyond the first level of corporate ownership where the concept of "pyramiding" of corporate structures appears to be present.

Your committee views the disclosure requirements imposed by the bill to be of critical importance in the process of detecting and deterring fraudulent and abusive practices within the medicare, medicaid, and the maternal and child health programs. Your Committee does not intend, however, for these requirements to be unduly burdensome on providers and other entities to which they apply. The provisions were designed to be incorporated into the ongoing certification or contractual process. It is, therefore, expected that their implementation and administration will be accomplished in such a way as to preclude unnecessary additional administrative burdens on those complying with them.

Penalties for Defrauding Medicare and Medicaid (Section 4)

Your committee bill would modify the penalty provisions in existing law which relate to those persons providing services under medicare and medicaid.

Existing law provides specific penalties under the medicare and medicaid programs for certain practices that have long been regarded by professional organizations as unethical, which are unlawful in some jurisdictions, and which contribute significantly to the cost of the programs. Such practices as the submission of false claims, or the soliciting, offering, or acceptance of kickbacks or bribes, including rebates or a portion of fees or charges for patient referrals, are misdemeanors under present law and punishable by a maximum $10,000 fine, up to one year imprisonment, or both. In addition, the making of false statements with respect to material facts concerning the conditions of health care facilities in order to qualify for certification under medicare and medicaid is considered a misdemeanor and punishable by a maximum $2,000 fine, up to six months in prison, or both.

Recent hearings and reports, however, indicate that such penalties have not proved adequate deterrents against illegal practices by some individuals who provide services under medicare and medicaid. In addition, these misdemeanor penalties appear inconsistent with existing Federal criminal code sanctions which make similar actions punishable as felonies. Also, it has been brought to the attention of the committee by U.S. Attorneys' offices which have utilized these Social Security Act sanctions in the prosecution of medicare and medicaid fraud cases that the existing language of these penalty statutes is unclear and needs clarification.

Your committee's bill would strengthen the penalty provisions in existing law which relate to persons providing services under medicare and medicaid. Most fraudulent acts now classified as misdemeanors would become felonies. Penalties for these acts would be increased to a maximum $25,000 fine, up to five years imprisonment, or both.

In addition, the bill would clarify and restructure those provisions in existing law which define the types of financial arrangements and conduct to be classified as illegal under medicare and medicaid.

It would make subject to the penalty provisions any person who solicits or receives any remuneration (1) in return for referring an individual to a person for the furnishing, or arranging for the furnishing of, items or services; or (2) in return for purchasing, leasing, or ordering, or arranging for, or recommending the puchasing, leasing, or ordering of goods, facilities, or services. Also, any person who offers or pays any remuneration to any person to induce such person to do similar activities would be subject to the penalty provisions.

Your committee's bill would define the term "any remuneration" broadly to encompass kickbacks, bribes, or rebates which may be made directly or indirectly, overtly or covertly, in cash or in kind (but would exclude any amount paid by an employer to an employee for employment in the provision of covered items or services).

The bill would specifically exclude the practice of discounting or other reductions in price from the range of financial transactions to be considered illegal under medicare and medicaid, but only if such discounts are properly disclosed and reflected in the costs for which reimbursement could be claimed. The committee included this provision to ensure that the practice of discounting in the normal course of business transactions would not be deemed illegal. In fact, the committee would encourage providers to seek discounts as a good business practice which results in savings to medicare and medicaid program costs.

In addition, the committee bill would allow States to suspend, for a period not to exceed one year, the eligibility of medicaid recipients convicted of defrauding the program. However, the misdemeanor penalty provision presently provided under existing law for conviction of such individuals would be retained (maximum fine of $10,000, up to one year imprisonment, or both) as would be the penalty for conviction of a beneficiary under the medicare program.

In its consideration of this bill, your committee has focused considerable attention on the activities of the Department of Justice to investigate and prosecute fraud in the medicare and medicaid programs. The committee believes that the Department must develop the resources to combat this complex type of criminal activity. Your committee has received a commitment from the Attorney General to strengthen departmental efforts in this area and intends to monitor those efforts quite closely. The letter of the Attorney General outlining departmental initiatives in this area follows:

Office of the Attorney General,
Washington, D.C., May 12, 1977.

Hon. Dan Rostenkowski,
*Chairman, Subcommittee on Health, Committee on Ways and Means,
House of Representatives, Washington, D.C.*

Dear Mr. Chairman: I am writing you again with reference to the proposal to include in H.R. 3 a mandate for the establishment of a separate and identifiable organizational unit within the Department's Criminal Division to carry out specified functions relating to investigation and prosecution of criminal violations in the programs of health insurance and medical assistance provided under the Social Security Act. As I indicated in my appearance before your Subcommittee, I fully concur in the need for vigorous investigation and prosecutions of fraudulent activities in the medicare-medicaid program. I strongly feel, however, that the aforementioned provision is unnecessary and would set an undesirable precedent by dictating in law a particular subordinate organization within the Criminal Division.

In recognition of the importance of taking effective action against medicare-medicaid abuses, we are currently taking the following steps.

1. We have within the Fraud Section of the Criminal Division a program fraud unit which coordinates Department efforts directed against program abuse and maintains regular liaison with program agencies including HEW.

2. We are currently working on preparation of a Medicaid Enforcement Manual for distribution to Assistant United States Attorneys to assist them in prosecuting medicaid-medicare cases.

3. We are meeting on a regular basis with the Inspector General and his staff of HEW in an attempt to develop strategies and enforcement priorities within medicaid-medicare areas.

4. There is a separate program fraud unit within the Public Integrity Section which focuses on situations involving corruption of government officials in the administration of programs.

5. We are attempting to identify significant cases in order to insure that ample resources are devoted to their development and prosecution.

6. Many of the larger of the United States Attorneys offices, including the Southern District of New York and Chicago, have established separate program fraud units within the district to focus on these types of offenses.

I have every intention of continuing emphasis in this area. I do respectfully recommend, however, against placing in the law the requirement of a specific organization entity for this purpose. I am afraid that other Congressional committees will feel that they must support similar organizational requirements in law for their programs to insure that such programs receive appropriate attention. A proliferation of special units would inevitably lead to confusion, lack of flexibility and be self-defeating of the purposes intended.

Sincerely,

GRIFFIN B. BELL, *Attorney General.*

In addition, your committee's bill modifies section 204(a) of Public Law 94–505, relating to the annual reports of the Health, Education and Welfare Inspector General, to require the Inspector General's report to include an evaluation of the performance of the Attorney General in the investigation and prosecuting of criminal violations relating to fraud in the medicare and medicaid programs and include any recommendations with respect to improving the performance of such activities.

Amendments Related to Professional Standards Review Organizations (Section 5)

Waiver of Other Review Requirements (Section 5(a))

Your committee's bill provides that where the Secretary finds a given Professional Standards Review Organization (PSRO) competent to perform required review functions, similar activities otherwise required by law would not apply, except to the extent specified by the Secretary.

Under present law, the Secretary is authorized to waive any or all of the review, certification, or similar activities otherwise required under the law where he finds, on the basis of substantial evidence of the effective performance of review and control activities by PSRO's, that the activity or activities are no longer needed for the provision of adequate review and control. The purpose of this provision was to avoid duplication of review functions. Current law does not specifically state that the waiver authority is applicable to conditionally designated organizations, although the language has been interpreted to permit such actions.

Your committee's bill would both clarify present law and simplify its application by providing that where the Secretary makes a formal determination that a given PSRO is competent to perform required review functions, the review, certification and similar activities otherwise required by law would not be applicable with respect to those providers, suppliers, and practitioners being reviewed by such PSRO, except to the extent specified by the Secretary. A finding by the Secretary under this subsection could be made both with respect to conditionally designated and qualified PSRO's. The provision would not affect other provisions of existing law relating to determinations with respect to conditions for eligibility to or payment of benefits (as distinct from reviews or certifications of medical necessity).

Modification of Requirements for Conditionally Designated PSRO's (Section 5(b))

Your committee's bill extends the time period for conditional designation of PSRO's and clarifies the language of present law pertaining to the duties and functions a PSRO must assume during this trial period.

Current law provides that each PSRO shall initially be designated on a trial basis for a period not to exceed two years. By the end of the period, the organization shall be considered a qualified organization only if the Secretary finds that it is substantially carrying out in a satisfactory manner the functions required of a PSRO with respect to institutional services in its area. When the legislation was enacted, it was anticipated that conditionally designated organizations would be able to assume review responsibilities with respect to all institutional services within a two-year period. Implementation of the program has been slower than anticipated with the major focus to date on review of inpatient hospital services. A number of conditionally designated organizations have or are approaching the end of their two-year trial period. While many are effectively performing reviews of services, they are technically not eligible for continuation of their conditional status or designation as qualified organizations.

The bill modifies the conditional designation provision of present law to provide for a conditional period not to exceed 48 months. The Secretary would be authorized to extend this period for an additional 24 months if an organization has, for reasons beyond its control, been unable to satisfactorily perform all of its required functions. The committee expects that this extension of the conditional period would be authorized only in unusual circumstances.

The bill also clarifies the requirement of present law that PSRO's must assume responsibility for review of all institutional services (including ancillary services) during the conditional period. Additionally, the bill clarifies the requirement that PSRO's must be reviewing long-term institutional care services (subject to the provisions of section 5(d) which leave the responsibility for review of services in intermediate care facilities with the State medicaid agency unless the Secretary finds the State is not performing effective review).

Review Requirements (Section 5(c))

Your committee's bill requires the Secretary to give priority to PSRO requests to review services provided in "shared health facilities"; mandates the development of ambulatory care review methodologies for use by PSRO's; requires a PSRO to undertake ambulatory care review not later than two years after it has achieved operational status; and modifies the language in current law pertaining to physicians excluded from participation in review activities.

Under current law, a PSRO is required to review only care provided by or in institutions. It may request authority to review other kinds of health services, and the Secretary may approve the request at his option. To date, little emphasis has been given to the assumption of review responsibility by PSRO's for other kinds of health care services.

The bill would require the Secretary to give priority to requests by PSRO's to review services in "shared health facilities" with the highest priority being assigned to requests from PSRO's located in areas with substantial numbers of such facilities. A "shared health facility" is defined as an arrangement meeting all of the following criteria:

(1) Two or more practitioners practice their professions at a common physical location;

(2) The practitioners share common space, services of supporting staff or equipment;

(3) The practitioners have a person (who may himself be a practitioner), paid on a percentage or other basis clearly unrelated to the value of the services provided, who either is in charge of or supervises substantial aspects of the operation or who makes available services of supporting staff who are not employees of such practitioners; and

(4) At least one of the practitioners receives from medicare, medicaid, and maternal and child health fee-for-service payments in excess of $5,000 for one month or $40,000 for 12 months.

The term "shared health facility" specifically excludes hospitals, skilled nursing facilities, home health agencies, federally approved health maintenance organizations, hospital cooperative shared services organizations meeting the requirements of section 501(e) of the Internal Revenue Code, or any public entities.

The definition of a "shared health facility" is designed to distinguish those types of ambulatory facilities (sometimes referred to as "Medicaid Mills") which are characterized by a high volume of services to medicaid patients (often of an excessive or unnecessary nature), and the payment of a percentage of the medicare and medicaid billings to the owner or manager of the facility, from legitimate group practice arrangements under which several practitioners render services at a common location. Since a shared health facility could evade the test of percentage arrangements, the Secretary has leeway to determine whether the payments to the owner or manager, while technically not a percentage of billings, are clearly unrelated to the value of the services provided by such person to the facility. By requiring a facility to meet all four criteria specified in the bill, it is expected that such legitimate arrangements among practitioners would be excluded from the definition. The Committee expects, therefore, that the Department will exercise judgment in applying this definition so as to assure that legitimate group practice arrangements are not inappropriately classified.

Recent congressional hearings and reports have documented widespread instances of fraud and abuse in certain types of ambulatory facilities which have come to be known as "Medicaid Mills." The definition of shared health facilities is designed to identify these specific types of arrangements in order to facilitate PSRO review of the services furnished by such facilities. Your Committee wishes to emphasize that a PSRO is not a fraud detection organization; its role is to render professional determinations as to the medical necessity and appropriateness of services. Thus, a PSRO will be expected, where it chooses to undertake review of services furnished by "shared health facilities," to review those services for the same purposes—to judge appropriateness and quality—that it would review services provided in other health care settings.

Under current law, PSRO's may request authority review ambulatory care services, i.e., those provided in clinics or doctors' offices. However, your committee notes that reliable ambulatory care review methodologies have not as yet been developed. The bill, therefore, requires the Secretary to develop, within two years, effective ambulatory care review methodologies for use by PSRO's. The bill further directs the Secretary, where he finds a PSRO capable of undertaking ambulatory care review, to require the organization to undertake such review not later than two years after it has achieved operational status. The Committee expects that in implementing this requirement, the Secretary will exercise judgment with respect to the varying capacities of PSRO's and, where appropriate, will establish a reasonable classification of ambulatory care review activities for an organization to undertake. Such classification might include specific categories of services or specific aspects of various service categories. Your committee further notes that "ambulatory care services" are those services not rendered by or in an institution. Institutional review, including review of services provided in hospital outpatient departments or emergency rooms, is a requirement of current law and must be conducted before an organization can achieve operational status.

Under current PSRO review provisions, a physician is precluded from reviewing health services provided to a patient if he was directly or indirectly involved in providing the services. Present law further precludes review by a physician of services furnished in any institution, organization, or agency if he or any member of his family has, directly or indirectly, any financial interest in such entity.

Your committee's bill would modify these restrictions to permit greater opportunity for physician participation in PSRO review activities. Under the bill, a physician would not be permitted to review services for which he was directly responsible (rather than directly or indirectly responsible as in present law) or services in an institution in which he or a member of his family has a "significant" financial interest (rather than "any" financial interest, as in present law.) The committee expects that in implementing this provision, HEW will employ the same definition of "significant" financial interest as is currently used in administering medicare.

The bill further provides that arrangements with PSRO's for reimbursement of the costs of review activities are to be made in a manner similar to that provided for medicare intermediaries (which includes provision for advances of funds and payment of administrative costs).

Conclusive Determinations for Payment (Section 5(d))

Your committee's bill provides that where a PSRO has been found competent by the Secretary and is performing specific review functions, medical determinations made in connection with such review shall be considered conclusive on those issues for purposes of payment. The bill provides a formal role for the States in the process of establishing and evaluating PSRO review of services provided through the medicaid program. The bill also precludes delegated review in skilled nursing facilities and provides that review of intermediate care facility services will be undertaken by a PSRO only if the Secretary finds that the State is not performing effective review in these facilities.

Under present law, medicare payments and the Federal share of medicaid payments may not generally be made for health care services which a PSRO, in the proper exercise of its duties, has determined to be medically unnecessary or inappropriate. However, the committee believes that it is necessary, in order to avoid the performance of disruptive duplicative reviews by medicare and medicaid agencies, to clarify the scope of the PSRO's authority and the role of the medicaid State agencies.

Accordingly, your committee's bill provides that where a conditionally designed or a qualified PSRO has been found competent by the Secretary to assume specific review responsibilities and is performing such reviews, a determination as to quality or necessity made in connection with such review would constitute the conclusive determination on those issues for purposes of payment. (Such determinations would be subject to the hearings and appeals provisions of present law.) Medicare fiscal intermediaries and State medicaid agencies would continue to be responsible for other types of reviews and determinations relating to program eligibility, coverage of services, audit, claims payment, fraud and abuse detection, and related activities.

Your committee has received comments from a number of States expressing concern over the potential impact of PSRO determinations on State medicaid budgets. The committee has concluded that since substantial State monies are involved it is appropriate that they be given an opportunity to evaluate a PSRO's capability to efficiently and effectively perform review of medicaid services. The bill, therefore, makes provision for the participation of States in the PSRO designation process and in the ongoing monitoring of PSRO review activities.

Your committee's bill requires a PSRO to consult with the medicaid State agency in the development of its formal review plan (required as a condition for designation) and in any modification of the plan involving assumption of review responsibility for additional categories of services. The bill provides the States with an opportunity to review and comment on the proposed conditional designation of a PSRO, the change in designation status from conditional to operational, and the assumption by the PSRO of responsibility for long-term care and ambulatory care review. Before the Secretary designates a PSRO or substantially adds to its functions, he is required to take the State's views into account. If his decision differs from the course recommended by the State, he must notify the State of the reason for his decision and allow them additional time to provide further support for their views.

The bill provides that a PSRO's determination shall constitute a conclusive determination for purposes of payment under medicaid only if the PSRO has entered into a memorandum of understanding (approved by the Secretary) with the appropriate State medicaid agency. The purpose of this memorandum is to delineate the relationship between the PSRO and the State agency. The requirement for a memorandum of understanding may be waived only if the State indicates that it does not wish to enter into such an understanding or if the Secretary finds that the State agency has refused to negotiate in good faith or in a timely manner with the PSRO involved.

A State medicaid agency may request a PSRO to include in its memorandum of understanding a specification of review goals and methods (in addition to those required in the PSRO's formal review plan) for the performance of its required functions. If the State medicaid agency and the PSRO are unable to agree on the inclusion of such items, the Secretary would review the requested specification and require that it be included in the memorandum if he determines that the review goals and methods are consistent with titles XI and XIX of the act and do not impair the effectiveness and uniformity of the PSRO's review of health care services under medicare and medicaid. For example, a State might request that a PSRO emphasize the prevention of unnecessary Friday admissions of medicaid patients for elective procedures not scheduled to be performed until Monday. Your committee notes that the PSRO's application of norms, criteria, and standards would not be affected by this provision; standards for quality, appropriateness and necessity of services would continue to be the same for both programs. If the PSRO found review of weekend admissions was appropriate, it would generally be applied to all patients whose care was reviewed by the PSRO.

Your committee intends that the Secretary shall not deny a State agency request solely because the PSRO has not been utilizing such a requested method or goal for the medicare program or because the PSRO cannot apply the method or goal to the medicare program due to differences in the patient populations. Rather, the Committee intends that where differences in the patient populations do not preclude uniform review by the PSRO, the Secretary's decision shall be based on his determination as to whether the PSRO can effectively apply such review methods or goals to the review of services provided under both the medicare and medicaid programs in order to ensure that the uniformity of PSRO review under the Social Security Act can be maintained.

The committee intends that any review specified by the State agency which the PSRO performs in accordance with its memorandum of understanding with the agency and pursuant to its review authority until title XI would be fully federally funded. In addition, the bill provides regular Federal matching if a medicaid State agency contracts with a PSRO to undertake additional review responsibilities, provided the State agency formally requests it and the performance of such responsibilities is provided for in an approved medicaid plan amendment For example, the State agency may request the PSRO to approve so-called administrative days, such as an additional day of hospital stay which may be required because there is no immediately available skilled nursing facility bed.

The bill also provides Federal financial participation to State medicaid agencies for the costs of monitoring the performance of review activities by PSRO's under State monitoring plans which have been approved by the Secretary. It is expected that the Secretary will develop criteria for approval of such plans and that they will not be approved where the proposed monitoring activities duplicate the purposes of PSRO review. The State medicaid agency may include in its plans for monitoring a specification of the performance criteria for judging PSRO effectiveness. Your committee has not mandated inclusion of such specifications in the State's monitoring plan because it is believed that most States during the development and initial implementation of State monitoring of PSRO review will not have such performance criteria developed. However, at such time as the State agency intends to utilize performance criteria for judging PSRO review effectiveness, your Committee expects the agency to discuss the criteria with the PSRO and to amend the State's monitoring plan to include the agreed-upon criteria.

The bill authorizes the State agency to request suspension of the PSRO's authority to make conclusive determinations if in the course of its monitoring activities it develops reasonable documentation that the PSRO review determinations have caused an unreasonable and detrimental impact either on total State medicaid expenditures or on the quality of care. Within thirty days of receipt of the documentation the Secretary is required to suspend all or part of the PSRO's conclusive determination authority under medicaid. (For example, he may suspend their review of long-term care services, but not hospital services. He may also take similar action with respect to PSRO determinations under medicare if he determines such action is appropriate.) During the suspension period the Secretary is required to conduct a reevaluation of the PSRO's capability to perform review activities and to inform the appropriate agencies, organizations, and congressional committees of any documentation submitted and actions taken.

The bill requires the Secretary to establish procedures and mechanisms governing his relationship to State agencies in connection with their respective responsibilities concerning memoranda of understanding, monitoring, and reevaluations. The Secretary is required to periodically consult with representatives of State agencies and PSRO's. Further, the appropriate State medicaid agency is permitted to be represented on any project assessments conducted by the Secretary. Your committee intends that the procedures and mechanisms developed by the Secretary shall promote smooth working relationships between all parties involved and shall involve a minimum of disruption in the orderly implementation of the PSRO program. Your committee further intends that State monitoring activities will become less intensive over time (particularly with respect to PSRO's which are no longer in conditional status) and will focus on problem areas which have been detected in the performance of PSRO review.

Your committee is aware of the fact that as PSRO's begin to review services provided in institutional settings other than hospitals, different requirements may be appropriate. Accordingly, the bill prohibits delegated review in skilled nursing facilities since these facilities have generally had far less experience in conducting in-house review activities than hospitals. Further, PSRO review of care in intermediate care facilities and public institutions for the mentally retarded (services which are paid for only under the medicaid program) would only be undertaken where the Secretary determines that the State is not performing effective review of the quality and necessity of services provided in such facilities. If the Secretary does make such a finding, and the PSRO is required to carry out the review, the committee expects that the PSRO would not delegate review to the intermediate care facility, just as they are prohibited from such delegation to skilled nursing facilities.

Clarification of Sanctions Provision (Section 5(e))

Current law specifies those conditions under which the Secretary may, at the recommendation of a PSRO, withdraw a medical care provider's eligibility to participate in Social Security Act medical care programs where it is determined that it is not willing, or cannot, carry out its obligations to order and provide only necessary care of acceptable quality.

The bill makes clear that the provision in question applies to any health care practitioner, or any hospital or other health care facility, agency, or organization which is subject to PSRO review.

National Council (Section 5(f))

The bill provides for staggered terms for members of the National Professional Standards Review Council.

Present law provides that the 11 members of the Council shall be appointed for three-year terms and may be eligible for reappointment. Your committee's bill would amend this provision. The general term for Council members would continue to be three years, except that for members appointed in 1979, four shall be appointed for a two-year term and three for a one-year term. All members would continue to be eligible for reappointment.

National Council Report (Section 5(g))

Section 5(g) would delete the requirement in present law for an annual report on its activities by the National Professional Standards Review Council and would require instead the submission by the Secretary of a detailed annual report on the PSRO program.

Under the new reporting requirement included in your committee's bill, the Secretary would be required to submit substantially more information concerning the cost and operation of the PSRO program than has previously been required of the National Council. Accordingly, the bill would delete the requirement for the National Council report as duplicative and unnecessary.

Exchange of Data and Information With Other Agencies (Section 5(h))

Your committee's bill would expand and clarify the circumstances under which the provision of data or information by PSRO's would not violate the confidentiality requirement of law.

Under present law, any data or information acquired by a PSRO in the exercise of its duties must be held in confidence and may not be disclosed to any person except (1) to the extent that may be necessary to carry out the purpose of the PSRO provisions, or (2) in such cases and under such circumstances as the Secretary shall by regulations provide to assure adequate protection of the rights and interests of patients, health care practitioners, or providers of health care. Interim regulations issued by the Department on December 3, 1976, provide for the disclosure of two types of information acquired by the PSRO:

1. Data and information acquired by the PSRO: (a) which has been published; (b) which has not been identified by the source as confidential; and (c) whose disclosures are not otherwise prohibited by law.

2. Summary statistics aggregated from the Uniform Hospital Discharge Data Set (UHDDS) to the extent that it is not identifiable to an individual patient or health care practitioner.

Your committee's bill would expand and clarify those circumstances under which the provision of data or information would not violate the confidentiality provisions to include: (1) provision of data or information by the PSRO, on the basis of its finding as to evidence of fraud or abuse, to Federal or State agencies recognized by the Secretary as having responsibility for the identification or detection of fraud and abuse activities; such data and information may be provided at the request of the recognized agencies at the discretion of the PSRO; and (2) provision of aggregate statistical data to agencies having responsibility for health planning and related activities under Federal or State law. The data and information furnished to the planning agencies would be provided in the format and manner prescribed by the Secretary or agreed upon by the agencies and the PSRO. Such data and information would be in the form of aggregate statistical data on a geographic, institutional, or other basis reflecting the volume and frequency of services furnished and the demographic characteristics of the population whose services are subject to review by the PSRO. However, the data would not identify any individual.

Data and information made available to Federal or State agencies recognized by the Secretary as having responsibility for identifying and investigating fraud and abuse may not be further disclosed except when the disclosure is made in the course of a legal, judicial, or administrative proceeding. Violation of this prohibition would result in application of the penalty specified in existing law.

Your committee has included this provision to facilitate the exchange of data and information with other agencies while at the same time assuring that the confidentiality of patient records will not be violated. The committee has received information that PSRO's which have identified suspected cases or widespread patterns of fraud and abuse have been unable to make the information available to enforcement agencies. Your committee also notes that the provision of aggregate statistical data to Federal and State planning agencies will enable those bodies to develop a more accurate picture of medical care patterns in their areas, facilitate planning for future resource needs, and prevent unnecessary duplicative data gathering activities.

Your committee's bill also includes a provision to protect patient records from subpena or discovery proceedings in a civil suit. This provision, however, would not preclude the subpena or discovery of originals or copies of the same documents in the possession of others.

Legal Expenses (Section 5(i))

Your committee's bill provides for payment of legal fees in connection with the defense of suits brought against a PSRO related to the performance of its functions. The bill would authorize the Secretary to assume responsibility for legal fees incurred in connection with the defense of any suit, action, or proceeding brought against the PSRO or any of its members or employees related to the performance of its functions. Your committee notes that while all PSRO's currently have liability insurance which covers such attorneys' fees, this provision would serve as an additional guarantee in the event such insurance is subsequently withdrawn.

Payment of PSRO Expenses (Section 5(j))

Your committee's bill would clarify the intent of present law that payment for PSRO expenses is to be made from Federal funds.

Under present law, expenses incurred by PSRO's are payable from medicare trust funds and from funds appropriated to carry out the other health care provisions of the Social Security Act. The bill would clarify that it is not intended that States or local governmental entities contribute toward these expenses, as they normally must do to receive Federal matching funds under title XIX.

Annual Reports (Section 5(k))

Current law does not require the preparation of a detailed report on the activities, cost, and impact of the PSRO program. Your committee believes that this information is necessary to determine the status of program operations, to evaluate the progress of program implementation, and to assess the program's effectiveness.

The bill therefore requires the Secretary to submit annual reports to the Congress by April 1 of each year beginning in 1978 on the administration, impact, and cost of the PSRO program during the preceding fiscal year. The reports must include program data on each PSRO; institutions and practitioners whose services are subject to review; services determined by PSRO's not to meet standards; penalties and sanctions; total costs under titles V, XI, XVIII, and XIX in the implementation of all required review procedures; changes attributable to PSRO activities; progress in adopting and implementing ambulatory review methodologies; results of program evaluation activities; extent to which PSRO's are performing reviews for other private or governmental programs; and legislative recommendations.

Report of the Secretary; Confidentiality of Medical Records (Section 5(l))

Your committee's bill requires the Secretary, after taking into account the recommendations of the Privacy Protection Study Commission, to submit recommendations to the Congress pertaining to the privacy of patients' medical records, the circumstances under which records may be appropriately examined and the safeguards that need to be established with respect to such examinations and the disclosure of records.

Your committee is concerned that sufficient safeguards may not currently exist to protect the privacy of patients' medical records. Existing policies with respect to access to medical records by agents of the Federal Government, as well as others, may provide opportunities for unnecessary invasions of individual rights of privacy. The Committee is convinced that the issue of confidentiality requires thorough reexamination. Attention needs to be given as well to the possible use of more stringent limitations on Federal access to records, though such limitations must be designed in such a way as not to impede the ability of the government to carry out necessary epidemiological and other research activities and to perform vital public health functions. It is the Committee's understanding that the Privacy Protection Study Commission has been conducting an in-depth study of these issues and will be submitting its final report in June 1977.

Your committee's bill therefore requires the Secretary to submit to the appropriate congressional committees, within three months of the issuance of the final report of the Commission, a report and legislative recommendations for appropriate procedures to maintain the confidentiality of all individually identifiable medical records, and to provide for appropriate safeguards against unwarranted inspection or disclosure of such records.

While recognizing the need for a thorough reexamination of the entire issue of the confidentiality of medical records, your committee has also included in the bill provisions affecting access to and the inspection of medical records by PSRO's and employees or agents of the Federal government. Under the bill, PSRO's and employees or agents of the Federal government may not inspect, acquire or require the disclosure of individually identifiable medical records unless the patient has executed a signed and dated consent statement authorizing inspection or disclosure for a specific time period, identifying the records to be inspected or disclosed, and specifying the purposes for which (and the agencies to which) such records may be inspected or disclosed.

Under the bill, the requirement of patient authorization would not apply, however, to the inspection, acquisition, or disclosure of an individually identifiable medical record relating to medical care which is paid for (in whole or in part) by the medicare or medicaid programs where such inspection, acquisition or disclosure (1) is by a PSRO for the purpose of reviewing services furnished to medicare or medicaid beneficiaries, or (2) is for the purpose of auditing for, investigating or prosecuting fraud or abuse in the provision of, or payment for, such medical care.

Your committee is cognizant of the fact that the Privacy Commission has recommended that legislative action on the issue of confidentiality of medical records is needed with respect to all types of medical records wherever located and by whomever maintained (including both private and public sites and holders of records) and with respect to the great variety of public and private purposes for which such records may be sought or needed. Thus, by including in your committee's bill the requirement for the Secretary to submit comprehensive legislative recommendations to the committee following the publication of the Privacy Commission's report, your committee is prepared to fully reassess the confidentiality issue at such time as the Secretary provides the legislative recommendations required by the bill.

Medical Officers (Section 5(m))

Your committee's bill would include medical officers in American Samoa, the Northern Mariana Islands and the Trust Territory of the Pacific Islands in the PSRO program. The committee notes that in these areas medical officers rather than doctors of medicine provide medical care. The bill would therefore permit medical officers licensed to practice medicine in these localities to participate in the PSRO program. These individuals may not, however, serve on the National Council or make any final determinations with respect to medical necessity or appropriateness of care provided by a duly licensed doctor of medicine or osteopathy.

Payment for Review of Part B Services Provided by Hospitals (Section 5(n))

Public Law 94–182, enacted on December 31, 1975, included an amendment to the medicare program which was designed to equalize reimbursement for PSRO hospital review activities whether such review was carried out by a hospital under delegation from a PSRO or by the PSRO itself. Previously, only delegated review activities could be funded out of the medicare trust funds. Under the new law, PSRO expenses in carrying out nondelegated review for hospital services covered under medicare part A or medicaid or the maternal and child health program would also be reimbursed through this mechanism. The law did not, however, provide for similar funding for PSRO review of hospital services covered under medicare part B.

Accordingly, the bill corrects this oversight by providing that funding for delegated review activities for services provided by a hospital which are covered under medicare part B shall be made from the medicare trust funds.

Statewide Councils (Section 5(o))

Your committee's bill extends the protection currently provided to members and employees of a PSRO from criminal prosecution or civil liability when carrying out PSRO functions to members and employees of Statewide Professional Standards Review Councils.

Issuance of Subpenas by the Comptroller General (Section 6)

Your committee's bill would give the Comptroller General of the United States the power to sign and issue subpenas to gain information regarding health programs authorized under the Social Security Act.

Currently, the Comptroller General of GAO does not have the statutory authority, under the Social Security Act, to issue subpenas in connection with GAO investigations into health programs authorized by that Act. In a December 29, 1976, letter to the committee, which was in response to an inquiry concerning Social Security Act subpena power for the General Accounting Office, the Acting Comptroller General stated that:

> From the overall perspective, we believe that the subpena power in question would be a useful tool. In all probability, the mere existence of such a power would be sufficient to preclude problems in most cases and, in our opinion, resort to its use would be relatively infrequent. We would thus favor the inclusion of subpena authority in the anticipated new legislation.

The bill would give the Comptroller General of GAO the power to sign and issue subpenas in order to gain information and facilitate review of medicaid, and the maternal and child health programs particularly with respect to investigations of fraudulent and abusive practices. In connection with GAO's statutory functions including investigations, examinations, and auditing, subpenas could be issued to gain access to pertinent books, records, documents, or other information.

Under resistance or refusal by an individual to obey a subpena, the bill would authorize the Comptroller General to request a court order requiring compliance.

In granting GAO the power to subpena books, records, and documents, the committee is aware that the personal medical records of beneficiaries and recipients could be subject to subpena. In the context of the bill personal medical records are defined to mean any information relating to an individual's medical or mental condition or treatment that is acquired by GAO in the course of its investigations into Social Security Act health programs, in a form that could identify the individual.

The committee strongly believes that confidentiality of such records must be protected and has, therefore, placed strict controls on the disclosure of such information by GAO personnel. The bill would prohibit the disclosure of personal medical records subpenaed by GAO to any person except those GAO employees whose official duties require seeing them. GAO personnel illegally disclosing such records would be subject to a $1,000 fine, six months imprisonment, or both; and if convicted, prosecution costs. In addition, the bill would exclude the copies of all personal medical records in GAO possession from subpena or discovery proceedings in a civil action. This exclusion, however, would not preclude the subpena or discovery of originals or copies of the same documents in the possession of others.

The bill would permit GAO disclosure of personal medical records only to Federal or State agencies authorized to investigate cases or patterns of fraud and abuse under Social Security Act health programs. Prior to such disclosure, however, the Comptroller General must determine that such records actually reveal evidence of fraud and abuse.

Suspension of Practitioners Convicted of Medicare- or Medicaid-Related Crimes (Section 7)

Your committee's bill requires the suspension of physicians or other individual practitioners from participation in medicare or medicaid if such practitioner has been convicted of a program-related criminal offense.

The committee has included this provision in response to the concern that some program violators have been permitted continued participation, often without interruption, in Federal health care programs. The committee feels that misuse of Federal and State funds is a very serious offense and that those convicted of crimes against the programs should not be permitted continued and uninterrupted receipt of Federal and State funds. The committee believes that this threat of suspension, together with the upgraded penalties authorized under the bill, will serve as a significant deterrent to fraudulent practices under medicare and medicaid.

Under current law, physicians or other individual practitioners who have been convicted of an offense related to their participation in medicare or medicaid are not automatically suspended from these programs and can continue to receive payment therefrom. The Secretary may suspend Federal payment to a person who has falsified information related to a request for payment. The Secretary may also suspend a person who bills the program for charges substantially in excess of the person's customary charges or who has furnished services found to be substantially in excess of an individual's needs, to be harmful, or to be of grossly inferior quality.

The bill requires the Secretary to suspend from participation under medicare, a physician or individual practitioner who he determines has been convicted of a criminal offense related to such individual's involvement in medicare or medicaid. To permit case-by-case determinations, the suspension would be for such period as the Secretary deems appropriate and no medicare payment could be made for any item or service furnished by such individual during this period. Individuals subject to suspension are those who are convicted on or after the date of enactment of the law or within such period prior to enactment as the Secretary may specify in regulation. Provision is made for appropriate notice to the individual and the public and hearing and judicial review of the Secretary's determination. In any case where the Secretary suspends a practitioner from participation in medicare he is required to promptly notify every State medicaid agency and the appropriate State or local licensing authority.

Whenever a State medicaid agency is notified by the Secretary that a practitioner has been suspended under medicare, it shall suspend such individual from participation in medicaid. This is intended to prevent practitioners from moving from one State to another in order to avoid the effect of the suspension. To conform the timing of suspensions, the medicaid suspension period shall not be less than the suspension period applicable to the individual under medicare. No medicaid program payments may be made for services provided by such individual during the suspension period.

In his notification to the licensing authority the Secretary shall request that investigations be made and sanctions be invoked, as deemed appropriate in accordance with the State's law and policy. The Secretary and Inspector General would be notified of whatever action, if any, is taken by these authorities.

The committee was concerned that imposition of this suspension, under certain unusual circumstances, could deny adequate access to medical care to persons eligible for services under medicare or medicaid. To ensure that this would not occur, the bill provides two remedies. First, the bill would authorize the Secretary to designate a community as a health manpower shortage area (as defined under title III of the Public Health Service Act) for purposes of placement of National Health Service Corps personnel, if he determines that imposition of a suspension would leave those residents of the area eligible under medicare or medicaid without adequate access to health services. Second, the bill permits the Secretary, on the request of a State, to waive a practitioner's suspension under the State's medicaid program. Your committee intends that such waivers be granted sparingly. It is expected that waivers will only be approved where imposition of the suspension would deny a community of needed medical service because of the shortage of practitioners in that area and no National Health Service Corps personnel have been assigned.

Disclosure by Providers of Owners and Certain Other Individuals Convicted of Certain Offenses (Section 8)

Your committee's bill requires all institutional providers of services participating in medicare, medicaid, or title XX State social service grant programs to disclose the names of owners and certain other individuals who have been previously convicted of fraud against any one of these programs.

Current disclosure of ownership provisions do not require institutional providers of services and other agencies and organizations certified to provide services under titles XVIII and XIX of the Social Security Act to disclose information about criminal records any of their owners and managerial employees may have. Similar information is also not required from institutional providers participating in title XX of the Social Security Act, a number of whom are also certified to provide services under medicare and medicaid. Existing procedures for determining this information are inadequate, time-consuming, and have permitted individuals previously convicted of such offenses to continue ownership or management in participating facilities or become owners or managers in other participating facilities without program administrators being aware of an individual's past activities which might have a bearing on a facility's future performance.

Lack of adequate disclosure of these individuals is an additional restraint on HEW's attempts to investigate and control program abuse. It has hampered and restricted Department efforts to limit the participation of those facilities and other organizations providing services under titles XVIII, XIX, or XX that are partially owned or controlled by persons convicted of criminal offenses against the programs.

Even when such individuals can be identified by the Department of HEW or State administering agencies, it is difficult under existing procedures to limit participation of facilites owned by these persons. Currently, no provisions exist to enable the Secretary of HEW or a State agency to refuse to enter into or to terminate provider agreements or contracts with institutional providers or other organizations owned by such individuals as long as existing conditions for participation under titles XVIII, XIX, or XX are met.

As a condition of participation, certification, or recertification under titles XVIII, XIX, or XX of the Social Security Act, the bill would require all institutional providers of services, or other agencies, institutions, or organizations to disclose to the Department of Health, Education, and Welfare or to the appropriate State agency the names of its owners, officers, directors, agents, or managing employees who have been convicted of a criminal offense against medicare, medicaid, or State social service grant programs. The bill specifies that when an application requesting such participation or certification contains the names of any such previously convicted individual, the Secretary of HEW or the State agency may refuse to enter into an agreement or contract with the institution to provide services under titles XVIII, XIX, or XX. In addition, the bill specifies that the HEW Inspector General must be informed of any such applications received and of any actions taken on them. The bill would also permit the Secretary or appropriate State agency to terminate existing provider agreements or contracts under titles XVIII, XIX, or XX, if the names of such individuals have not been disclosed, as required.

In applying the disclosure requirements to convicted persons who are officers, directors, agents, or managing employees of the institution, as well as to convicted persons with ownership interests, the committee feels that this parallel requirement is necessary in order to ensure that program administrators are aware of the renewed involvement of these persons in participating institutions.

The bill would specifically define the term "managerial employee" to mean a person who exercises operation or managerial control over the institution or one who directly or indirectly conducts the day-to-day operations of the institution including, but not limited to, an institution's general manager, business manager, administrator, and director. The bill would define the owner of an institution as any person who has a direct or indirect ownership or control interest of at least five percent in the institution.

Federal Access to Records (*Section 9*)

Under present law, State plans under medicaid are required to provide for agreements with every person or institution providing services whereby such persons or entities will keep complete records of services provided under the program and furnish the State agency, upon request, with information regarding any payments claimed under the program. Similar access to records by the Secretary is not required. The committee feels this could hamper Federal efforts to obtain information necessary to examine potential instances of fraudulent and abusive activities. Your committee bill therefore specifically permits the Secretary to have access to records of persons or institutions providing services under medicaid in the same manner presently provided to State medicaid agencies.

Claims Processing and Information Retrieval Systems for Medicaid Programs (*Section 10*)

Your committee's bill permits States to send explanation of benefits forms to a sample of medicaid recipients and still be entitled to increased Federal matching for operation of approved management information systems. No explanation of benefit forms would be required in the case of services which are confidential in nature.

Present law authorizes an increase in Federal matching to 75 percent toward the costs of operating an approved medicaid claims processing and information retrieval system if the system provides explanation of benefits information to all recipients. The committee has been informed that this strict requirement for explanation of benefit forms in every case has limited the growth of approved systems. In addition, questions have been raised about the cost effectiveness of this requirement because of the high volume of claims for services provided under medicaid.

The bill therefore modifies the current requirement by permitting the increased matching if the system provides explanation of benefits information to a sample group of recipients. The committee expects that the samples will be of sufficient size and sufficiently representative of the population served and the services rendered to enable the identification of any questionable or unusual patterns. It is the intention of the committee that all confidential services, and services integrally related to a confidential service, be deleted from the explanation of benefit forms in order to assure privacy for the medicaid patient. States will be expected to institute appropriate safeguards to accomplish this.

Your committee notes that this change in the medicaid statute does not constitute a new entitlement to higher Federal matching, but merely increases the workability of the existing provision.

Medicaid As Payor of Last Resort (Section 11)

Your committee's bill precludes Federal matching payments for expenditures under medicaid for services which a private insurer would have an obligation to pay except for a provision of its insurance contract which has the effect of limiting or excluding such obligation because the individual is eligible for or receiving medicaid.

Under current law, States or local agencies administering medical assistance plans are required to take all reasonable measures to ensure that third parties legally liable to pay for any medical care rendered to medicaid recipients meet their legal obligations. However, some private insurance policies contain a provision that limits the insurance companies' liability to the amount not covered by medicaid. In some cases, State insurance commissioners have not taken action to stop this practice. When it occurs, the medicaid program is forced to assume the costs despite the existing subrogation requirement.

The bill would provide an incentive to States to stop this practice by stopping all Federal matching payments for expenditures made under the plan for care or services provided to the extent the private insurer (as defined by the Secretary) would have been obligated to pay except for a provision of its contract which has the effect of limiting or excluding such obligation because the individual is receiving assistance under medicaid.

Study and Review of Medicare Claims Processing (Section 12)

Your committee's bill directs the Comptroller General to conduct a comprehensive study of the claims processing system under medicare for the purpose of determining what modifications should be made to achieve more efficient claims administration.

Under medicare part A, groups or associations of providers can nominate an organization to serve as a fiscal intermediary between the providers and the government. An individual member of an association or group of providers that has nominated one organization as intermediary may select some other organization if this is satisfactory to the organization and HEW, or alternatively it may elect to deal directly with the government. HEW may not enter into an agreement with an organization unless it finds that such agreement is consistent with efficient and effective administration. The Social Security Administration has selected 10 hospital-nominated organizations to serve as intermediaries. This includes the Blue Cross Association which carries out its claims administration activities through 73 statewide and local Blue Cross Plans. Under medicare part B, the Secretary contracts with carriers to perform claims processing activities. Carriers are selected to serve specified geographic areas. There are 47 carriers, including 32 Blue Shield plans. Both intermediaries and carriers are reimbursed on a cost basis for carrying out their activities.

The Committee believes that it is necessary to conduct a reexamination of the administrative framework of the medicare program in order to assess the need for possible modifications.

Your committee bill therefore directs the Comptroller General to conduct a comprehensive study and review of the administrative structure established for processing claims under medicare. The study is to determine whether and to what extent more efficient claims administration could be achieved by reducing the number of carriers and intermediaries, making a single organization responsible for processing claims under parts A and B in a particular geographic area, paying for claims processing on the basis of a prospective fixed price, providing other types of incentive payments for efficiency, or by other modifications in existing structure and procedures. The Comptroller General would be required to submit a report containing his findings and recommendations to the Congress by July 1, 1979.

Abolition of Program Review Teams Under Medicare (Section 13)

Your committee's bill repeals the provisions in current law relating to program review teams.

The Social Security Amendments of 1972 included a provision authorizing the Secretary to suspend or terminate medicare payments to a supplier of services found to have abused the program. In the case of such a suspension or termination, Federal participation was also to be withheld for medicaid payments made in behalf of such supplier. This provision was included to permit HEW to bar future payments to suppliers who have made a practice of furnishing inferior or harmful supplies or services, engaging in fraudulent activities, or consistently overcharging for their services.

To assist him in making determinations under this section, the Secretary was required to establish program review teams in each State. These professionally-based bodies were to advise the Secretary concerning such matters as whether excessive, harmful, or grossly inferior care is being rendered to patients. Your committee believes that the functions of program review teams relating to the review of the quality and appropriateness of services are essentially duplicative of the functions required to be performed by PSRO's.

The bill therefore deletes the requirements in current law pertaining to the establishment and responsibilities of program review teams. The committee expects that the appropriate PSRO will instead be available to advise the Secretary in cases that require the application of professional medical judgment.

Amendments Relating to Fiscal Intermediaries (Section 14)

Your committee's bill authorizes the Secretary, after taking into account the provider's nomination and after applying the appropriate standards and criteria required under this section, to assign and reassign providers to available intermediaries. He is also authorized, after applying the required standards and criteria, to designate regional intermediaries or a national intermediary with respect to a class of providers. The bill requires the Secretary to develop standards, criteria, and procedures for evaluating the adequacy of intermediary performance, and the efficiency and effectiveness of program administration, and to apply such standards and criteria in making determinations as to the participation and role of intermediaries in the program. Intermediaries are required to provide access by the Secretary to necessary data and information.

Under part A of medicare, groups or associations of providers of services, i.e., hospitals, extended care facilities, and home health agencies, can nominate an organization to act as a fiscal intermediary between the providers and the Secretary. An individual member of an association or group of providers which has nominated one organization as intermediary may select some other organization as its intermediary if this is satisfactory to the organization and the Secretary, or alternatively, it may elect to deal directly with the Secretary. The Secretary may enter into an agreement with a nominated organization only if he finds that this would be consistent with efficient and effective administration and that the organization is able and willing to assist providers in the application of safeguards against unnecessary utilization of services.

Your committee notes that the provision giving providers considerable latitude in their selection of intermediaries was included in the original medicare law in order to facilitate a smooth transition to the new health insurance program. While recognizing the contribution intermediaries generally have made toward the successful implementation of the medicare program, your committee believes that some potential for conflicts of interest exists under a system where intermediaries are responsible for fulfilling title XVIII requirements on the one hand, while on the other, their continued role as intermediaries is often contingent upon the providers' satisfaction with them. While the committee does not mean to imply that such conflicts are pervasive, or that many intermediaries have been lax in performing their functions, your committee has received some evidence, particularly in the case of home health agencies, of ineffective intermediary performance.

Your committee is also aware that the results of some of the current measures now used to evaluate intermediary performance are not always reliable indicators of performance. For example, for the quarterly reporting period July-September 1976, the adjusted cost per claim ranged from $2.73 to $7.21 with a weighted national average of $4.50. For the same time period, the adjusted number of claims per 100 man hours ranged from 155 to 399 with a weighted national average of 242. The committee recognizes that existing performance measures have not been sufficiently refined to determine the extent to which the variances reflect actual differences in costs rather than differences in accounting and reporting practices. The committee further notes that even where cost differences occur, lower costs do not necessarily imply a more efficient and effective operation. Other factors, such as the types of claims processed, are relevant to the assessment of performance. The committee, therefore, believes that it is imperative that more precise and uniform standards and criteria for evaluating the performance of intermediaries in the administration of the program need to be developed and that such objective standards and criteria need to be applied by the Secretary in making determinations with respect to the renewal or termination of agreements, as well as the assignment of providers, and the designation of regional or national intermediaries.

The bill therefore includes provisions designed to permit improvements in the administration of the hospital insurance program. In the interest of efficient and economical program administration, the bill authorizes the Secretary to assign and reassign providers to available intermediaries. While the bill retains the present provision of law allowing a provider to designate a preference through the nomination process, the Secretary would not be bound by a provider's choice. His decision must be based on a finding made, after applying the required standards and criteria with respect to the intermediary chosen by the provider, that in this particular instance reassigning a provider to another intermediary will result in more effective and efficient administration of the program. Your committee's bill requires that if the Secretary makes a determination which is not in accord with the provider's preference, the provider and his chosen intermediary be given a full explanation of the reasons for the Secretary's determination, and the intermediary be provided with an opportunity for a hearing.

The bill also authorizes the Secretary to designate regional intermediaries or a national intermediary to perform the required functions with respect to a class of providers (such as home health agencies) if he determines, after applying the appropriate standards and criteria to all affected intermediaries, that such designation would result in more effective and efficient administration. Such designations may not be made until the affected providers and intermediaries are provided with a full explanation of the reasons for his determination and the intermediaries are granted an opportunity for a hearing.

Your committee's bill further provides that determinations by the Secretary with respect to the assignment or reassignment of a provider to an intermediary other than the one nominated by the provider and the designation of a regional or national intermediary would be subject to judicial review in accordance with the appropriate provisions of the Administrative Procedures Act. It is your committee's intent to assure that in making such determinations the Secretary complies with the requirements of due process applicable to such administrative decisions. Moreover, your committee expects that such determinations will not be implemented, in the event an intermediary contests the

Secretary's determination, until such time as the affected intermediary has exhausted the appeal rights available to it under this bill.

The bill requires the Secretary to develop standards, criteria, and procedures to enable him to evaluate intermediaries' performance of the claims processing and other related functions required to be performed by them and to permit him to make objective determinations with respect to the efficiency and effectiveness of program administration. The Secretary is required to develop such standards, criteria and procedures by October 1, 1978, and apply them in making determinations relating to the renewal or termination of agreements with intermediaries, the assignment or reassignment of providers and the designation of regional or national intermediaries beginning on that date.

The bill further requires that agreements with intermediaries provide for access by the Secretary to all data, information and claims processing operations as he may find necessary to enable him to perform his required functions.

Disclosure by Providers of the Hiring of Certain Former Employees of Fiscal Intermediaries (*Section 15*)

Your committee's bill would require a provider of services under the medicare program to notify the Secretary promptly of its employment of an individual who at any time during the preceding year was employed in a managerial, accounting, auditing or similar capacity by a fiscal intermediary or carrier who had served that provider.

The committee was distressed to learn that in certain cases providers have specifically recruited and employed personnel of the fiscal intermediary serving it, apparently in order to assist the provider in justifying questionable accounting and cost reporting procedures. The committee strongly opposes this type of hiring practice which it sees as potentially subverting the integrity of the intermediary-provider relationship, including the integrity of the auditing process. The committee expects the Department of HEW to utilize the information gained under the notification required under the bill to discourage such practices, especially when such information suggests possible conflict of interest situations.

Providers who hire employees of fiscal intermediaries, particularly accountants and auditors who have been involved in auditing that provider, should be on notice that this committee will be following such practices closely.

Payment for Durable Medical Equipment (*Section 16*)

Your Committee's bill would modify the present methods for reimbursing medicare beneficiaries for expenses incurred in obtaining durable medical equipment. The intent of this modification is to reduce program expenditures and assure greater protection for beneficiaries against the need to pay excessive rental fees.

Present law provides for reimbursement under part B of medicare for expenses incurred in the rental or purchase of durable medical equipment used in the patients' home. The beneficiary has the option to rent or purchase such equipment. In the case of purchase, reimbursement is generally made in monthly installments equivalent to amounts that would have been paid had the equipment been rented.

Reimbursement may be made on a lump-sum basis for purchased equipment that is relatively inexpensive, i.e., items for which the reasonable charge is $50 or less.

Where a beneficiary elects to rent equipment, medicare will continue to reimburse him for 80 percent of his rental expenses as long as his medical need for the equipment continues. A study conducted by GAO showed that rental payments under the program for durable medical equipment required over an extended period of time frequently exceeded, by a substantial amount, the reasonable purchase price of the equipment. Moreover, beneficiaries were also overpaying for equipment since they are liable for the 20 percent coinsurance amount.

The Social Security Amendments of 1972 added provisions to the law to help avoid unreasonable expenses to the program and to beneficiaries resulting from prolonged rentals of equipment. These provisions authorized the Secretary to experiment with alternative reimbursement mechanisms, including the use of lease-purchase arrangements and lump-sum payments for purchased equipment where it could be determined in advance that the use of the equipment would be medically necessary for an extended period of time. Although the Department has not conducted the extensive experimentation contemplated by the legislation, sufficient evidence is available to indicate that changes in the reimbursement methods are needed to deal with the long-standing problems arising under the durable medical equipment provision of law.

To remedy these problems, your Committee's bill makes several changes in the methods used in reimbursing beneficiaries and suppliers for durable medical equipment. First, the bill requires the Secretary to determine, on the basis of medical evidence, whether the expected duration of medical need for the equipment warrants the presumption that purchase would be less costly or more practical than rental, and would not impose financial hardship on the beneficiary. Where such a presumption can be made, the Secretary would require purchase of the equipment and would provide reimbursement on the basis of a lump-sum payment or on the basis of a lease-purchase arrangement. Since lease-purchase would generally be the preferred mode of payment, and would ordinarily provide the greatest degree of cost-effectiveness for the program and the beneficiary alike, the bill specifically directs the Secretary to take steps to encourage suppliers, through whatever administrative arrangements he finds feasible and economical, to make equipment available to beneficiaries on a lease-purchase basis.

Secondly, the bill retains the provision in existing law which authorizes the Secretary to waive the 20 percent coinsurance requirement with respect to the purchase of used durable medical equipment whenever the purchase price is at least 25 percent less than the reasonable charge for comparable new equipment.

Funding of State Medicaid Fraud Control Units (Section 17)

Your committee's bill authorizes 90 percent Federal matching payments for fiscal years 1978–1980, for the establishment and operation of State medicaid fraud control units.

Your committee is concerned that sufficient efforts have not been made to date to identify and prosecute cases of medicaid fraud. In the absence of effective investigative units, individuals engaging in fraudulent practices are able to continue their activities virtually unchecked. Sections of the bill provide for criminal sanctions and suspension actions for those convicted of medicaid fraud. However, strengthened penalties must be coupled with strengthened investigatory powers in order to assure that those engaging in criminal activities are identified and prosecuted. Further, the combination of rigorous enforcement and criminal sanctions should serve as a deterrent to similar practices by other providers and practitioners.

During the hearings held on this legislation, testimony was presented showing that where a separate investigative entity has been established, the rate of prosecutions and convictions has been substantially increased. For example, there was testimony that in the period from 1970 to January 1975, there was not a single prosecution in New York State for medicaid fraud arising out of the operation of a nursing home. In January 1975, a special office was established to examine the rapidly growing scandal in the nursing home industry. As a result of its investigations, grand juries have indicted more than 90 individuals mostly for medicaid fraud. To date, there have been 27 convictions and the office has forced payment of more than four million dollars in criminal restitution—an amount several hundred thousand dollars in excess of the office's first year budget.

Your committee has learned that a number of States are interested in establishing or strengthening existing medicaid fraud control units. However, in view of the fiscal constraints being experienced by many of the States, the current 50 percent administrative matching rate has not served as a sufficient incentive to the establishment or expansion of such units. Your committee believes that a short-term increase in the Federal matching rate of 90 percent will enable States to establish effective investigative entities and expand existing efforts. After these units have been operational for a few years, their recoveries from prosecutions should begin to equal or exceed the cost of operation. Therefore, under the bill, the increased matching rate would only be in effect for three years.

The bill, therefore, provides for 90 percent Federal matching for fiscal years 1978–1980 for the costs incurred in the establishment and operation (including the training of personnel) of State fraud control units meeting specified requirements, subject to a quarterly limitation of the higher of $125,000 or one-quarter of one percent of total medicaid expenditures in such State in the previous quarter.

To be eligible for the increased matching rate, the State medicaid fraud control unit must be a single identifiable entity of State government which the Secretary certifies (and annually recertifies) as meeting specific requirements. Such entity must be a unit of the office of the State Attorney General or of another department of State government which has statewide prosecutorial authority, and such unit must be separate and distinct from the State medicaid agency. The entity is required to conduct a statewide program for the investigation and prosecution of violations of all applicable State laws relating to fraud in connection with the provision of medical assistance and the activities of medicaid providers. Such unit is not however required to examine potential instances of recipient fraud; this function may continue to be the responsibility of the State medicaid agency. The fraud control unit must have procedures for reviewing complaints of the abuse and neglect of patients by health care facilities, and, where appropriate for acting on such complaints or for referring them to other State agencies for action. The entity is required to provide for the collection, or referral for collection, of overpayments made to health care facilities. In order to promote effective and efficient conduct of the entity's activities, it must be organized in a manner to achieve these objectives and it must employ auditors, attorneys, and investigators and other necessary personnel. The entity is further required to submit an application and annual report containing information deemed necessary by the Secretary to determine whether the entity meets these requirements. To facilitate implementation of this section, the Secretary is required to issue regulations within 90 days of enactment.

The committee wishes to emphasize the need for the employment of highly skilled auditors, attorneys, and investigators specially trained in the area of medicaid fraud. The committee has received substantial evidence of the complex schemes employed by those engaging in fraudulent activities and notes that the only way such practices can be effectively addressed by utilizing persons specially skilled in uncovering these activities.

The committee intends that the increased matching rate authorized under this section be made available to existing State fraud control units providing they meet (or appropriately modify their operation so as to meet) the specified requirements.

Report on Home Health and Other In-Home Services (Section 18)

Your committee's bill would require the Secretary of Health, Education, and Welfare to report to Congress on home health and other in-home services authorized under titles XVIII, XIX, and XX of the Social Security Act.

The committee is concerned that, with respect to home health and in-home services authorized to be provided under medicare, medicaid, and title XX social service programs, more effective methods need to be developed to assure the quality of services provided and efficiency in administration of the programs, and more effective efforts to curb fraud and abuse. While it is understood that there are, by necessity, differences among these programs in entitlement to the services and the types of services covered, it is the feeling of the committee that any efforts to develop methods of quality assurance and administrative efficiency should, where possible and practical, provide for coordination between the programs, particularly with respect to requirements for providers of services and reimbursement methods.

The Secretary is, therefore, directed to submit within one year a report to the appropriate committees in Congress analyzing all aspects of the delivery of home health and in-home services authorized under these titles. Further, since the goal is to prescribe specific standards in the programs to assure high quality home health services and the protection of the health and safety of recipients of such services, the Secretary is required to report on regulatory changes needed and to recommend appropriate statutory changes with respect to quality assurance and administrative efficiency. It is the feeling of the committee that this study should be conducted by the Secretary of Health, Education, and Welfare in view of the extensive information gathered by the Department during recent regional hearings on home health care and the subsequent activity of the Department in analyzing this information. The Secretary is to include in this report an analysis of the impact of his recommendations on the demand for and cost of services authorized under the programs and the method of financing any recommended increase in the provision of such services.

Uniform Reporting Systems For Health Services Facilities and Organizations (Section 19)

Your committee's bill would require the Secretary to establish for each of the different types of health services facilities and organizations a uniform system for the reporting of such items as cost of operation, volume of services, rates, capital assets and bill data. This reporting system would be mandated for use by medicare and medicaid providers and such use would be phased in by type of provider.

A persistent problem under the medicare and medicaid programs as currently structured is the presence of variations in the information contained in medicare and medicaid cost reports. Since it is generally agreed that the existence of comparable cost and related data is essential for effective cost and policy analysis, the assessment of alternative reimbursement mechanisms and, in certain situations, the identification and control of fraud and abuse, the Subcommittee believes it is necessary to correct the deficiencies in the present reporting system under these programs. Your committee believes that this problem can be resolved by requiring the implementation of a uniform reporting system for all operational and capital costs of health care organizations.

Accordingly, the bill requires the Secretary to establish for each type of health service facility or organization a uniform system for the reporting of the following types of information:

(1) The aggregate cost of operation and the aggregate volume of services;

(2) The costs and volume of services for various functional accounts and subaccounts;

(3) Rates, by category of patient and class of purchaser;

(4) Capital assets, as defined by the Secretary, including (as appropriate) capital funds, debt service, lease agreements used in lieu of capital funds, and the value of land, facilities, and equipment; and

(5) Discharge and bill data.

It is your committee's intent that the uniform reporting system for each type of health service facility or organization provide for appropriate variation in the application of the system to different classes of facilities or organizations within that type. The Secretary would be required to develop and establish uniform reporting systems, after consultation with interested parties, for hospitals, skilled nursing facilities and intermediate care facilities within a year following enactment of this legislation, and for other types of health service facilities and organizations (such as home health agencies) within two years of enactment.

Under the bill, the Secretary would require all medicare and medicaid providers of services to submit reports to the Secretary of the aforementioned cost-related information in accordance with the uniform reporting system. For hospitals, skilled nursing facilities, and intermediate care facilities, these uniform reports would be required beginning with their first fiscal year that begins more than six months after the reporting system has been promulgated by the Secretary. For all other types of health service facilities or organizations, the reporting requirement will only be implemented at such time (after such systems are promulgated for these institutions) as the Secretary deems to be most productive. After establishing the uniform systems of reporting, the bill requires the Secretary to monitor their operation, assist with support demonstrations and evaluations of the effectiveness and cost of the operation of such systems, encourage State adoption of such systems and periodically revise the systems to improve their effectiveness and diminish their cost.

Under the bill, the Secretary would be required to provide such information obtained through use of the uniform reporting system as may be necessary to assist health systems agencies and State health planning and development agencies in carrying out such agencies' functions.

Although proposals have been made to require uniform accounting as well as uniform reporting, the bill does not mandate a uniform accounting system. Your committee was not prepared to conclude that a uniform accounting system is necessary in order to generate the required comparable data. Your committee is inclined to believe at this time that the uniform reporting system, with specific documentation for the reported costs as part of the organization's accounting system, is sufficient. Recognizing that further study of this complex issue may be warranted, the committee believes that it would be more appropriate to undertake such study in the context of deliberations on proposed cost containment legislation, rather than the anti-fraud and abuse legislation.

IV. COST OF CARRYING OUT THE BILL AND EFFECT ON THE REVENUES

In compliance with subdivision (C) of clause 2(l)(3) of rule XI of the Rules of the House of Representatives, the statement relative to the estimated costs of carrying out the bill provided to your Committee by the Director of the Congressional Budget Office follows:

CONGRESSIONAL BUDGET OFFICE,
U.S. CONGRESS,
Washington, D.C., June 3, 1977.

Hon. AL ULLMAN,
Chairman, Committee on Ways and Means, U.S. House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: Pursuant to Section 403 of the Congressional Budget Act of 1974, the Congressional Budget Office has reviewed H.R. 3, the Medicare-Medicaid Fraud and Abuse Amendments, with regard to its potential cost impact.

The provisions in H.R. 3 are intended to clarify and extend current statute in order to facilitate both state and federal efforts to monitor

Section 5(b)(1) amends section 1154(b) of the Social Security Act by extending the conditional designation period for a period not to exceed 48 months (except as provided in the new section 1154(c)). Section 5(b)(1) clarifies the requirement of current law that PSRO's must assume responsibility for review of all services provided by or in institutions (including ancillary services) and any other services the Secretary may require during the trial period.

Section 5(b)(2) amends section 1154 of the Social Security Act by redesignating subsection (c) as subsection (d) and by inserting a new subsection (c). The new subsection (c) provides that if the Secretary finds that a conditionally designated organization has been unable to perform satisfactorily all of the required duties and functions for reasons beyond the organization's control, he may extend such organization's trial period for an additional period not exceeding twenty-four months.

Section 5(c)(1) amends section 1155(a)(6) of the Social Security Act by precluding a physician from reviewing those services which he was directly responsible for providing or services furnished in an institution in which he or any member of his family has a significant financial interest. Section 5(c)(1) amends section 1155(f)(2) of the Social Security Act by providing that arrangements with PSRO's for reimbursement of the costs of review activities are to be made in a manner similar to that provided under section 1816(c) of the Social Security Act (pertaining to medicare intermediaries).

Section 5(c)(1) further amends section 1155 of the Social Security Act by striking the existing subsection (g) and substituting a new subsection.

The new section 1155(g)(1) provides that not later than two years after the date of enactment of this Act, the Secretary, through the conduct of demonstration projects or otherwise, shall develop effective ambulatory care review methodolopies for use by PSRO's in performing review responsibility with respect to ambulatory care services.

The new section 1155(g)(2) provides that where a PSRO (whether designated on a conditional basis or otherwise) requests review responsibility with respect to services furnished in shared health facilities, the Secretary must give priority to such request, with the highest priority being assigned to requests from organizations located in areas with substantial numbers of shared health facilities.

The new section 1155(g)(3) provides that the Secretary shall require any PSRO which is capable of exercising review responsibility with respect to ambulatory care services to perform review responsibility with respect to such services on and after a date not later than two years after the date the organization has been designated as a fully qualified PSRO.

Section 5(c)(2) amends section 1101(a) of the Social Security Act (definitions) by adding a new paragraph (9).

The new paragraph (9) defines "shared health facility". The term means any arrangement whereby—

(a) two or more health care practitioners practice their professions at a common physical location;

(b) such practitioners share (i) common waiting areas, examining rooms, treatment rooms, or other space, (ii) the services of supporting staff, or (iii) equipment;

(c) such practitioners have a person (who may himself be a practitioner)—

(i) who is in charge of, controls, manages, or supervises substantial aspects of the arrangement or operation for the delivery of health or medical services at such common physical location, other than the direct furnishing of professional health care services by the practitioners to their patients; or

(ii) who makes available to such practitioners the services of supporting staff who are not employees of such practitioners; and

who is compensated in whole or in part, for the use of such common physical location or support services pertaining thereto, on a basis related to amounts charged or collected for the services rendered or ordered at such location or on any basis clearly unrelated to the value of the services provided by the person; and

(d) at least one of such practitioners received payments on a fee-for-service basis under titles V, XVIII, and XIX in an amount exceeding $5,000 for any one month during the preceding 12 months, or in an aggregate amount exceeding $40,000 during the preceding 12 months.

The term "shared health facility" does not include a provider of services (as defined in section 1861(u) of this Act), a health maintenance organization (as defined in section 1301 of the Public Health Service Act), a hospital cooperative shared services organization meeting the requirements of section 501(e) of the Internal Revenue Code of 1954, or any public entity.

Section 5(d)(1) amends section 1158 of the Social Security Act by adding a new subsection (c).

The new subsection (c) provides that where a PSRO (whether designated on a conditional basis or otherwise) has been found competent by the Secretary to assume review responsibility with respect to specified types of health care services or specified providers or practitioners of such services and is performing such reviews, determinations of medical necessity and appropriateness made pursuant to paragraphs (1) and (2) of section 1155(a) in connection with such reviews shall constitute the conclusive determination on those issues subject to the hearings and appeals provisions (section 1159 of the Act) and the requirements pertaining to memorandum of understanding and State monitoring (sections 1171(a)(1) and 1711(d)(3)) for purposes of payment. No reviews with respect to those determinations shall be conducted, for purposes of payment, by medicare intermediaries which are parties to agreements entered into by the Secretary pursuant to section 1816, medicare carriers which are parties to contracts entered into by the Secretary pursuant to section 1842, or single State medicaid agencies.

Section 5(d)(2)(A) amends section 1152(b)(2) of the Social Security Act to require the development and submission of a formal review plan in accordance with the new section 1152(h).

Section 5(d)(2)(B) adds a new section 1152(h). The new section 1152(h) requires an organization to consult with the appropriate single State medicaid agency during the development and preparation of its formal plan under section 1115(b)(2) or of any modification of such plan to include review of services in skilled nursing facilities (as defined in section 1861(j)) or intermediate care facilities (as defined in section 1905(c)) or review of ambulatory care services. The plan or any such modification shall be submitted to the Governor of such State, at the time of its submission to the Secretary, for his comments. Before making findings pursuant to section 1152(b)(2) or a finding regarding the organization's capability to perform review of long-term care and ambulatory care services, the Secretary shall consider any comments submitted to him by the Governor before the end of the thirty-day period beginning on the date of submission of the plan or of any such modification. If, after considering such comments, the Secretary intends to make findings which are adverse to such comments, he shall provide the Governor making such comments with the opportunity to submit additional evidence and comments on such intended findings during a period of not less than thirty days ending before the findings become effective.

Section 5(d)(2)(C) amends section 1154 of the Social Security Act by adding a new subsection (e). The new subsection (e) requires the Secretary, in determining whether a conditionally designated PSRO is substantially carrying out its duties in a satisfactory manner and should be considered a qualified organization, to follow the procedures specified in the new section 1152(h) (concerning the Secretary's consideration of comments of the Governor of the State in which the organization is located).

Section 5(d)(2)(D) adds a new section 1171 to the Social Security Act entitled: "Memorandums of Understanding; Federal-State Relations Generally".

The new section 1171(a)(1) specifies that (except as provided in paragraph (2)) no determination of appropriateness or medical necessity made by a PSRO pursuant to section 1155(a) (1) and (2) shall constitute conclusive determinations under section 1158(c) for purposes of payment under medicaid, unless such organization has entered into a memorandum of understanding, approval by the Secretary, with the appropriate single State medicaid agency. The memorandum of understanding shall delineate the relationship between the organization and the State agency and provide for the exchange of data or information, administrative procedures, coordination mechanisms, and modification of the memorandum at any time that additional responsibility for review by the organization is authorized by the Secretary.

The new section 1171(a)(2) provides that the requirement of paragraph (1) may be waived by the Secretary if (a) the State agency indicates to him that it does not wish to enter into a memorandum of understanding with the organization involved, or (b) he finds that the State agency has refused to negotiate in good faith, or in a timely manner with such organization.

The new section 1171(b)(1) provides that the State agency may request a PSRO which is entering into such a memorandum of understanding with the agency to include in the memorandum a specification of review goals or methods (additional to any such goals or methods contained in the organization's formal plan) for the performance of the organization's duties and functions.

The new section 1166(b) requires a PSRO to provide, in accordance with procedures established by the Secretary, data and information:

(1) to assist Federal and State agencies recognized by the Secretary as having responsibility for identifying and investigating cases or patterns of fraud or abuse. This data and information shall be provided by the PSRO to such agencies at their request at the discretion of the PSRO on the basis of its findings with respect to evidence of fraud or abuse.

(2) to assist the Secretary, and such Federal and State agencies recognized by the Secretary as having health planning or related responsibilities under Federal or State law (including health systems agencies and State health planning and development agencies authorized under title XV of the Public Health Service Act), in carrying out appropriate health care planning and related activities. The data and information shall be provided in such format and manner as may be prescribed by the Secretary or agreed upon by the responsible Federal and State agencies and the PSRO and shall be in the form of aggregate statistical data (without identifying any individual) on a geographic, institutional, or other basis reflecting the volume and frequency of services furnished, as well as the demographic characteristics of the population subject to review by the PSRO.

The new subsection (b) further provides that the existing penalty provision (redesignated as subsection (d)) shall not apply to the disclosure of any data and information received under this subsection. However, the penalty shall apply to the disclosure (by the agency receiving such data and information) of any such data and information described in paragraph (1) unless such disclosure is made in a judicial, administrative, or other formal legal proceeding resulting from an investigation conducted by the agency receiving the data and information.

The new section 1166(d) provides that no patient record in the possession of a PSRO, a Statewide PSR Council, or the National PSR Council shall be subject to subpena or discovery proceedings in a civil action.

Section 5(i) amends section 1167 of the Social Security Act by adding a new subsection (d).

The new subsection (d) requires the Secretary to make payment to a PSRO (whether conditionally designated or qualified) or to any member or employee thereof, who furnishes legal counsel or services to such organization, in an amount equal to the reasonable amount of the expenses incurred (as determined by the Secretary) in connection with the defense of any suit, action, or proceeding brought against such organization, member, or employee related to the performance of any duty or function of such organization, member, or employee.

Section 5(j) amends section 1168 of the Social Security Act by adding a new sentence. The sentence clarifies that the Secretary is required to make payments for PSRO expenses from Federal funds without any requirement for the contribution of funds by any State or political subdivision.

Section 5(k) adds a new section 1172 to the Social Security Act entitled, "Annual Reports."

Section 7(b) amends section 1902(a) of the Social Security Act by adding a new paragraph (39) and making the appropriate conforming changes.

The new Section 1902(a)(39) provides that (subject to the provisions of section 1902(g)) whenever the State medicaid agency is notified of a suspension action under medicare, it shall promptly suspend such physician or practitioner from participation in its medicaid program for not less than the period specified in the suspension notice, no payment may be made under its medicaid program with respect to any items or services furnished by such physician or practitioner during the suspension period.

Section 7(c) amends section 1902 of the Social Security Act by adding a new subsection (g).

The new section 1902(g) provides that the Secretary may waive suspension under medicaid if the single State medicaid agency submits a request to the Secretary for such waiver and if the Secretary approves such request.

Section 7(d) amends section 332(c) of the Public Health Service Act (relating to considerations in the designation of health manpower shortage areas) by adding a new paragraph (3).

The new paragraph (3) provides that the Secretary in determining whether to designate an area as a health manpower shortage area, shall take into consideration the extent to which individuals who are (1) residents of the area, members of the population group, or patients in the medical facility or other public facility under consideration for designation, and (2) entitled to have payment made for medical services under title XVIII or XIX of the Social Security Act, cannot obtain such services because of suspension of physicians from the programs under such titles.

Section 7(e) provides that the amendments made by section 7 shall apply with respect to determinations and designations made on or after the date of enactment. The amendment made by section 7(b) pertaining to medicaid suspensions shall become effective on October 1, 1977.

SECTION 8. DISCLOSURE OF PROVIDERS OF OWNERS AND CERTAIN OTHER INDIVIDUALS CONVICTED OF CERTAIN OFFENSES

Section 8(a) adds a new section 1127 to the Social Security Act entitled: "Disclosure by Institutions, Organizations, and Agencies of Owners and Certain Other Individuals Who Have Been Convicted of Certain Offenses."

The new section 1127(a) specifies that as a condition of participation in or certification or recertification under the programs established by titles XVIII, XIX, and XX, any hospital, nursing facility, or other institution, organization, or agency shall be required to disclose to the Secretary or to the appropriate State agency the name of any person who—

(1) has a direct or indirect ownership or control interest of 5 percent or more in such institution, organization, or agency or is an officer, director, agent, or managing employee of such institution, organization, or agency, and

(2) has been convicted (on or after the date of enactment, or within such period prior to that date as the Secretary shall specify

in regulations) of a criminal offense related to the involvement of such person in any of such programs.

Section 1127(a) requires the Secretary or appropriate State agency to promptly notify the Inspector General of: 1) the receipt from any institution, organization, or agency or any application or request for such participation, certification, or recertification which discloses the name of any such person, and 2) the action taken with respect to such application or request.

The new section 1127(b) defines "managing employee" for purposes of this section. The term means, with respect to an institution, organization, or agency, an individual, including a general manager, business manager, administrator, and director, who exercises operational or managerial control over the institution, organization, or agency, or who directly or indirectly conducts the day-to-day operations of the institution, organization, or agency.

Section 8(b)(1) amends section 1866(a) of the Social Security Act by adding a new paragraph (3).

The new Section 1866(a)(3) provides that the Secretary may refuse to enter into or renew an agreement under medicare with a provider of services if any person who has a direct or indirect ownership or control interest of 5 percent or more in such provider, or who is an officer, director, agent, or managing employee of such provider, is a person described in the new section 1127(a).

Section 8(b)(2) amends section 1866(b)(2) of the Social Security Act by providing that the Secretary may terminate a provider agreement if he determines that such provider (at the time the agreement was entered into) did not fully and accurately make any disclosure required of it by section 1127(a).

Section 8(c) amends section 1903 of the Social Security Act by adding a new subsection (n).

The new section 1903(n) provides that the medicaid State agency may refuse to enter into any contract or agreement with a hospital, nursing home, or other institution, organization, or agency for purposes of participation under the State plan, or otherwise to approve an entity for such purposes, if any person who has a direct or indirect ownership or control interest of 5 percent or more in such institution, organization, or agency, or who is an officer, director, agent, or managing employee of such entity is a person described in section 1127(a). This action may be taken whether or not such institution, organization, or agency has in effect an agreement entered into with the Secretary pursuant to section 1866 or is subject to a suspension of payment order issued under medicaid. Notwithstanding any other provisions of section 1903, the State agency may terminate any such contract, agreement, or approval if it determines that the institution, organization, or agency did not fully and accurately make any disclosure required of it by section 1127(a) at the time such contract or agreement was entered into or such approval was given.

Section 8(d) amends section 2002(a) of the Social Security Act by adding a new paragraph (15).

The new section 2002(a)(15) provides that any State may refuse to enter into a contract or other arrangement with a provider of services for purposes of participation under title XX or otherwise to approve a provider for such purposes, if any person who has a direct or indirect ownership or control interest of 5 percent or more in such provider, or who is an officer, director, agent, or managing employee is a person described in section 1127(a). The State may terminate any such contract, arrangement, or approval if it determines that the provider did not fully and accurately make any disclosure required of it by section 1127(a) at the time the contract or arrangement was entered into or the approval was given.

Section 8(e) provides that the amendments made by this section shall apply with respect to contracts, agreements, and arrangements entered into and approvals given pursuant to applications or requests made on and after the first day of the fourth month beginning after the date of enactment.

SECTION 9. FEDERAL ACCESS TO RECORDS

Section 9 amends section 1902(a)(27)(B) of the Social Security Act to require State plans to include provision for Federal access to records of persons or institutions providing services under medicaid in the same manner currently provided to State medicaid agencies.

SECTION 10. CLAIMS PROCESSING AND INFORMATION RETRIEVAL SYSTEMS FOR MEDICAID PROGRAMS

Section 10(a) amends section 1903(a)(3)(B) of the Social Security Act by modifying the requirement for explanation of benefits forms required as a condition of increased Federal matching for operation of approved medicaid management information systems. The section provides that such notification shall be provided to each individual who is furnished services covered by the plan, or to each individual in a sample group of individuals who are furnished such services, of the specific services (other than confidential services) so covered.

Section 10(b) provides that the amendment made by subsection (a) shall apply with respect to calendar quarters beginning after the date of enactment.

SECTION 11. RESTRICTION ON FEDERAL MEDICAID PAYMENTS

Section 11(a) amends section 1903 of the Social Security Act by adding a new subsection (o), the new section 1903(o) provides that, notwithstanding the preceding provisions of section 1903, no Federal medicaid matching payments shall be made to a State for expenditures for medical assistance provided for an individual to the extent that private insurer (as defined by regulation) would have been obligated to provide such assistance but for a provision of its insurance contract which has the effect of limiting or excluding such obligation because the individual is eligible for or receiving medicaid benefits.

Section 11(b) provides that the amendment made by subsection (a) shall apply with respect to medical assistance provided under a State medicaid plan on and after January 1, 1978.

SECTION 12. STUDY AND REVIEW OF MEDICARE CLAIMS PROCESSING

Section 12 requires the Comptroller General of the United States to conduct a comprehensive study and review of the administrative

SECTION 19. ESTABLISHMENT OF UNIFORM REPORTING SYSTEMS FOR DIFFERENT TYPES OF HEALTH SERVICES FACILITIES AND ORGANIZATIONS; MAKING OF REPORTS UNDER MEDICARE AND MEDICAID PROGRAMS IN ACCORDANCE WITH SUCH SYSTEMS

Section 19(a) amends part A of title XI of the Social Security Act by adding a new section 1121, entitled "Uniform Reporting Systems for Health Services Facilities and Organizations." New section 1121(a) requires the Secretary to establish, by regulation, a uniform system of reporting for hospitals, skilled nursing facilities, intermediate care facilities, home health agencies, health maintenance organizations, and other types of health services facilities and organizations receiving payments under the Social Security Act.

New section 1121(a) further requires that for each type of health services facility or organization reporting under the uniform system, the following information will be required:

(1) the aggregate cost of operation and the aggregate volume of services;

(2) the costs and volume of services for various functional accounts and subaccounts;

(3) rates, by category of patient and class of purchaser;

(4) capital assets, as defined by the Secretary, including (as appropriate) capital funds, debt service, lease agreements used in lieu of capital funds, and the value of land, facilities, and equipment; and

(5) discharge and bill data.

In addition, new section 1121(a) requires that the uniform reporting system for a type of health services facility or organization shall provide for appropriate variation in the application of the system to different classes of facilities or organizations within that type and shall be established, to the extent practicable, consistent with the cooperative system for producing comparable and uniform health information and statistics described in section 306(e)(1) of the Public Health Service Act.

New section 1121(b) requires the Secretary to:

(1) monitor the operation of the systems established under subsection (a);

(2) assist with and support demonstrations and evaluations of the effectiveness and cost of the operation of such systems and encourage State adoption of such systems; and

(3) periodically revise such systems to improve their effectiveness and diminish their cost.

New section 1121(c) requires the Secretary to provide the information obtained through use of the uniform reporting system described in new section 1121(a) in a useful manner and format to appropriate agencies and organizations, including health systems agencies (designated under section 1515 of the Public Health Service Act) and State health planning and development agencies (designated under section 1521 of such Act), as may be necessary to carry out such agencies' and organizations' functions.

Section 19(b)(1) amends section 1861(v)(1) of the Social Security Act by adding a new section 1861(v)(1)(F) which requires that regulations pertaining to the reasonable cost of services under the medicare program set forth under section 1861(v) must require each provider of services under the medicare program (other than a fund) to make reports to the Secretary on information in new section 1121(a) in accordance with the uniform reporting system (established under that section) for that type of provider.

Section 19(b)(2) amends section 1902(a) of the Social Security Act (as already amended by sections 2(b), 3(c), and 7(b) of this legislation) by adding a new section 1902(a)(40). New section 1902(a)(40) requires each health services facility or organization which receives payments under a State plan for medical asisstance and of a type for which a uniform reporting system has been established under new section 1121(a) to make reports to the Secretary on information described in that section in accordance with the uniform reporting system (established under that section) for that type of facility or organization.

Section 19(c)(1) requires the Secretary to establish the systems described in new section 1121(a) of the Social Security Act only after consultation with interested parties and:

(a) for hospitals, skilled nursing facilities, and intermediate care facilities, not later than the end of the one-year period, and

(b) for other types of health services facilities and organizations, not later than the end of the two-year period,

beginning on the date of enactment of this legislation.

Section 19(c)(2)(A) specifies that the amendments made by section 19(b) will apply, with respect to operations of a hospital, skilled nursing facility, or intermediate care facility, on and after the first day of its first fiscal year which begins after the end of the six-month period beginning on the date a uniform reporting system is established (under new section 1121(a) of the Social Security Act) for that type of health services facility.

Section 19(c)(2)(B) specifies that the amendments made by section 19(b) will apply to the operation of a health services facility or organization other than a hospital, skilled nursing facility, or intermediate care facility, on and after the first day of its first fiscal year which begins after the date the Secretary determines appropriate for implementing the reporting requirements for that type of facility or organization.

Section 19(c)(2)(C) specifies that the amendments made by section 19(b)(2) will apply to State plans for medical assistance approved under title XIX of the Social Security Act, on and after October 1, 1977 (except as provided by sections (19(c)(2) (B) and (B)).

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is summarizing the activities of the Office during the preceding calendar year. Such report shall include, but need not be limited to—

(1) an identification and description of significant problems, abuses, and deficiencies relating to the administration of programs and operations of the Department disclosed by such activities;

(2) a description of recommendations for corrective action made by the Office with respect to significant problems, abuses, or deficiencies identified and described under paragraph (1);

(3) an evaluation of progress made in implementing recommendations described in the report or, where appropriate, in previous reports; and

(4) a summary of matters referred to prosecutive authorities and the extent to which prosecutions and convictions have resulted.

Such report shall also include an evaluation of the performance of the Attorney General in the investigation and prosecution of criminal violations relating to fraud in the programs of health insurance and medical assistance provided under titles XVIII and XIX of the Social Security Act, and shall include any recommendations with respect to improving the performance of such activities.

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95th Congress
1st Session
HOUSE OF REPRESENTATIVES
Rept. No. 95-393
Part II

MEDICARE-MEDICAID ANTIFRAUD AND ABUSE AMENDMENTS

REPORT

BY THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

[To accompany H.R. 3]

together with

SEPARATE AND ADDITIONAL VIEWS

[And Including Cost Estimate of the Congressional Budget Office]

July 12, 1977.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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95th Congress } HOUSE OF REPRESENTATIVES { **Rept. 95-393**
1st Session } { **Part 2**

MEDICARE-MEDICAID ANTI-FRAUD AND ABUSE AMENDMENTS

July 12, 1977.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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Mr. Staggers, from the Committee on Interstate and Foreign Commerce, submitted the following

REPORT

together with

SEPARATE AND ADDITIONAL VIEWS

[Including cost estimate of the Congressional Budget Office]

[To accompany H.R. 3 which on Jan. 4, 1977, was referred jointly to the Committee on Ways and Means and the Committee on Interstate and Foreign Commerce]

The Committee on Interstate and Foreign Commerce, to whom was referred the bill (H.R. 3) to strengthen the capability of the Government to detect, prosecute, and punish fraudulent activities under the medicare and medicaid programs, and for other purposes, having considered the same, report favorably thereon with four amendments and recommend that the bill as amended do pass.

The amendments are as follows:

1. On page 1, strike out line 5 and all that follows through line 7 on page 27 and insert in lieu thereof the following:

PROHIBITION AGAINST ASSIGNMENT BY PHYSICIANS AND OTHERS OF CLAIMS FOR SERVICES; CLAIMS PAYMENT PROCEDURES FOR MEDICAID PROGRAM

Sec. 2. (a)(1) Section 1842(b)(5) of the Social Security Act is amended by adding at the end thereof the following new sentence: "No payment which under the preceding sentence may be made directly to the physician or other person providing the service involved (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) shall be made to anyone else under a reassignment or power of attorney (except to an employer or facility as described in clause (A) or (B) of such sentence); but nothing in this sub-has included in its reported amendments some provisions which relate solely to part A of the medicare program (Hospital Insurance Benefits for the Aged and Disabled), which is in the jurisdiction of the Committee on Ways and Means. (Similarly, that committee has included in its reported amendments provisions relating solely to medicaid, which is the jurisdiction of the Interstate and Foreign Commerce Committee). It should be noted that substantive action on the amendments in these cases were carried out by the committee on jurisdiction. Adoption by the other committee was generally done pro forma. All provisions which were within both committees' jurisdiction, however, were fully considered by each.

II. Summary of the Bill

As reported, the provisions of H.R. 3, the Medicare-Medicaid Anti-Fraud and Abuse Amendments, are focused on six major areas: Strengthened program penalty sanctions, increased disclosure of information, needed improvements in the Professional Standards Review program, administrative reform, and other Medicaid amendments. The summary presented below briefly outlines the principal features of the bill as reported.

PROGRAM PENALTY SANCTIONS

1. The bill modifies the penalty provisions in existing law which relate to those persons providing services under medicare and medicaid. Most fraudulent acts now classified as misdemeanors are to become felonies. Penalties are to be increased to a maximum $25,000 fine, up to five years imprisonment, or both. The types of financial arrangements and conduct to be classified as illegal have been clarified. In addition, States will now be permitted to suspend the eligibility of medicaid recipients convicted of defrauding the program. However, the misdemeanor penalty presently provided under existing law for conviction of such individuals is retained, as is the misdemeanor penalty for the conviction of a beneficiary under the medicare program. The bill also requires the Health, Education, and Welfare Inspector General to include in his annual report an evaluation of the effort of the Department of Justice in the investigation and prosecution of fraud in the medicare and medicaid programs and his recommendations for improvement of that effort. (Section 4)

2. The bill requires the Secretary of Health, Education, and Welfare to suspend, for such period as he deems appropriate, from participation under medicare and medicaid, an individual practitioner who has been convicted of a criminal offense related to such individual's involvement in medicare or medicaid. When the Secretary suspends an individual, he must also notify the appropriate State licensing authorities, requesting that investigation be made and sanctions invoked in accordance with the State's law and public policy. (Section 7)

1. (a) The bill requires, as a condition of participation or certification in either medicare, medicaid or the maternal and child health program, the annual disclosure to the Secretary or the appropriate State agency by the participating entity of the identity of any person

who has a five percent or more ownership interest in the entity. These disclosure of ownership provisions will apply to medicare and medicaid providers of services (including independent clinical laboratories and renal disease facilities), entities furnishing services for which payment may be claimed under medicaid or the maternal and child health program (but not including any individual or group of practitioners), and medicare carriers or intermediaries and medicaid fiscal agents. Providers of services would also have to disclose similar ownership information about any subcontractor, five percent or more of which is owned by the provider. (Section 3)

(b) Furthermore, the bill modifies existing medicare and medicaid provisions relating to termination of medicare provider agreements or suspension of medicaid payments to health care entities by adding a requirement that a provider must comply with a request specifically addressed to it by the Secretary or the medicaid State agency for full and complete information as to any significant business transactions between it and any subcontractors or between it and wholly-owned suppliers. Finally, in the case of subcontractors having more than $25,000 in annual business transactions with a provider, compliance would be required with similar requests related to ownership information pertaining to the subcontractor. (Section 3)

2. The bill requires all institutional providers of services, or other agencies, institutions, or organizations, as a condition of participation or certification in medicare, medicaid or the social services programs under Title XX of the Social Security Act to disclose, in the application for participation or certification, the names of owners, officers, directors, agents, or managing employees who have been convicted of fraud against the medicare, medicaid, or State social service grant programs. Where an application contains the name of any such previously convicted individual, the Secretary or the State agency can refuse to enter into an agreement or refuse to contract with the applicant. The Inspector General of the Department of Health, Education, and Welfare must be informed of the receipt of any such applications and of any action taken on them. (Section 8)

3. The bill authorizes the Comptroller General of the United States to sign and issue subpenas in order to obtain necessary information and facilitate review of Social Security Act health programs. The Comptroller General will also be authorized, upon resistance or refusal by an individual to obey a subpena, to request a court order requiring compliance with the subpena. The bill would impose criminal sanctions for unauthorized disclosure by the GAO of individually identifiable personal medical records and would protect such records from subpena or discovery proceedings in connection with a civil suit. (Section 6)

4. The bill requires any provider of services participating in medicare to promptly notify the Secretary of its employment of an individual who, at any time during the preceding year, was employed in a managerial, accounting, auditing, or similar capacity by a medicare fiscal intermediary or carrier that services the provider. (Section 15)

5. The bill allows Federal access to the records of persons or institutions providing services under medicaid in the same manner that such access is presently provided to State agencies. (Section 9)

PROFESSIONAL STANDARDS REVIEW

The bill includes several provisions designed to clarify the nature and scope of PSRO review responsibilities, to enhance the capacity of PSRO's to perform reviews of the necessity and appropriateness of services more effectively, and to improve the administration and coordination of review activities so as to assure that program funds are properly expended. Thus, section 5 of the bill provides:

(1) for the termination of other duplicative review activities when the Secretary determines that a PSRO is competent to perform its review responsibilities; that the determinations of PSRO's so recognized by the Secretary with respect to the necessity and appropriateness of care are conclusive for purposes of program payment; and that the role of the State in the process of establishing and evaluating PSRO review of services provided through the medicaid program will be increased and made more specific;

(2) that a PSRO may be conditionally designated for a period not to exceed 48 months (with authority for the Secretary to extend the period for an additional 24 months where warranted by unusual circumstances); and that PSRO's must assume review responsibilities for institutional services during this period;

(3) for the Secretary to develop ambulatory care review methodologies for use by PSRO's and to make such methodologies available within 2 years; to require a PSRO, where he finds it is capable of undertaking ambulatory care review, to undertake such review no later than 2 years after it becomes fully operational; and to give priority to requests by PSRO's to review services in "shared health facilities";

(4) that the Federal Government may assume the defense costs incurred by a PSRO in a liability suit related to the performance of its functions;

(5) for the disclosure of information with respect to evidence of fraud to designated Federal and State law enforcement agencies (with a prohibition against access to PSRO records in the case of subpena or discovery proceedings in a civil action), and for the disclosure of aggregate statistical data to Federal and State health planning agencies;

(6) for the annual submission to the Congress by the Secretary of a comprehensive report on the administration, cost, and impact of the PSRO program;

(7) for a prohibition against any PSRO disclosing to a Federal official, or a Federal official having access to, any individually identifiable medical record in the possession of a PSRO relating to medical care not provided or paid for by the Federal Government without the specific consent of the patient. The Department of HEW would also be required to submit its legislative recommendations to the Congress as to the appropriate procedure for maintaining the confidentiality of individual medical records. These recommendations would be made after taking into consideration the final report of the Privacy Protection Study Commission and must be submitted to the Congress no later than 90 days after the Privacy Commission's report is issued; and

(8) for several clarifying administrative and technical changes designed to enhance a PSRO's operational capacity. (Section 5)

ADMINISTRATIVE REFORM

1. The bill authorizes the Secretary to assign and reassign providers to available intermediaries, after taking into account any preferences expressed by the providers and after applying objective performance standards to the original nominee of the provider prior to making a reassignment. Any assignment action he takes must be based on a finding that it will result in more efficient and effective administration of the program. Before making any assignment or reassignment that is not in accord with the provider's choice, the Secretary must furnish to the provider and its chosen intermediary a full explanation of his findings with respect to efficiency and effectiveness and provide an appropriate opportunity for a hearing, which is subject to judicial review.

The Secretary is also authorized to designate regional intermediaries or a national intermediary with respect to a class of providers (e.g., home health agencies) where he determines that, after applying objective performance standards to agencies or organizations that would be adversely affected, such designation will result in more efficient and effective administration of the program. In a similar manner to that mentioned above, this authority to designate with respect to a class of providers is subject to a requirement that the Secretary fully explain to the affected parties his findings with respect to efficiency and effectiveness and provide an appropriate opportunity for a hearing which is subject to judicial review. (Section 14)

2. The bill requires the Secretary to establish for each of the different types of health services institutions a uniform system for the reporting of such items as cost of operation, volume of services, rates, capital assets and bill data. This reporting system would be mandated for use by medicare and medicaid providers and such use would be phased in by type of provider. (Section 19)

3. The bill repeals the program review team provisions of present law. The functions formerly performed by such teams with respect to the quality and utilization of services will be performed by Professional Standards Review Organizations. (Section 13)

4. The bill would encourage each State to establish an office separate from the medicaid program agency to prepare and prosecute cases of suspected fraud and abuse in the program by providing for 90 percent Federal matching funds for expenditures to establish and operate State medicaid fraud control units. (Section 17)

5. The bill also requires States to make provision in their State medicaid plan for claims payment procedures which ensure that 90 percent of the bills submitted by eligible noninstitutionally-based providers will be reimbursed within 30 days, and 99 percent within 60 days. The State would not be cited for noncompliance if the Secretary found the State was acting in good faith to achieve this goal. (Section 2)

6. The bill directs the Comptroller General to conduct a comprehensive review of the administrative structure for the processing of medicare claims. (Section 12)

7. The bill requires the Secretary of Health, Education, and Welfare to report to the Congress within 12 months after enactment of this legislation with an analysis and recommendations relating to all aspects (including the availability, administration, provision, reimbursement procedures and cost) of the delivery of home health services under medicare, medicaid and the title XX social services program. (Section 18)

TECHNICAL REVISION

1. Your committee's bill clarifies existing law to insure that a power of attorney cannot be used to circumvent the prohibition in existing law against the use of "factoring" arrangements in connection with the payment of provider claims by the medicare and medicaid programs. (Section 2)

2. The bill modifies the provisions of existing law related to the rental or purchase of durable medical equipment to mandate that the Secretary require the purchase of such equipment where purchase will be less costly than extended rental payments. (Section 16)

3. The bill increases individual state's incentives to adopt a computerized medicaid claims processing and information retrieval system by modifying one current requirement for higher Federal matching funds for the development and operation of this system. The bill would require such systems to provide explanation of benefits information to only a sample group of medicaid recipients rather than to each recipient as is currently required. (Section 10)

4. The bill would preclude Federal matching of State medicaid expenditures that result from State laws or contracts which exclude or limit insurance benefits because an individual is eligible for medicaid. (Section 11)

OTHER MEDICAID AMENDMENTS

The bill provides an additional six-month period to States to meet the requirements of the current law concerning review of care delivered in long-term care institutions. The section provides that if a State is in compliance for the year period ending December 31, 1977, the Secretary shall waive all (or such part as is appropriate) of the reduction which would otherwise be imposed on those States that failed to fulfill the requirements of the law during previous periods. Further the section specifies: 1) that the Secretary must provide States with a 30-day notice before reducing funds, 2) that the Secretary must complete his validation surveys of State reviews and give notice of any reduction resulting from his findings within 9 months of the close of the year in question, and 3) that good faith attempts to perform reviews of all institutions, and actual review of all large institutions and 98 percent of all other institutions, will be considered full compliance with the requirements of the law. (Section 20)

III. COST OF LEGISLATION

As reported by the Committee, H.R. 3 as amended provides authorization for an increase in the Federal matching rate for the Medicaid program as follows:

(a) It provides 90 percent Federal matching for State expenditures to support programs of educational and technical assistance to expedite the filing and payment of claims. The higher Federal matching is authorized for a 3-year period only. A maximum of $5 million in aggregate expenditures annually is placed on funds available at the higher matching rate.

(b) It provides 90 percent Federal matching for expenditures to establish and operate State Medicaid fraud control units which meet certain specified standards. The higher Federal matching is authorized for a 3-year period only. A maximum on the annual amount any State could receive at the higher matching rate is established at one-quarter of 1 percent of Medicaid expenditures in the State, or $500,000, whichever is greater.

The bill also delays reductions of Medicaid matching funds imposed on the States because of failure to meet the requirements of the law for review in long-term care institutions. The reduction is waived if a State comes into compliance with the requirements of the law by December 31, 1977.

However, because the provisions of the law are designed to increase program efficiency and ability to detect and prosecute fraud, reductions in program expenditures resulting from H.R. 3 are expected to offset any increase in expenditures resulting from the provisions of the bill. As set forth in the Congressional Budget Office estimate which appears later in this report, no increase in cost is estimated to occur.

IV. Purpose and Background of the Bill

In recent years, numerous hearings, studies, and investigations undertaken by this committee and other committees of the Congress, the General Accounting Office, and other Federal and State agencies have demonstrated that there exist, to a disturbing degree, fraudulent and abusive practices associated with the provision of health services financed by the medicare and medicaid programs. The disclosures to date have focused on a broad range of improper activities which are not restricted to one particular class of providers or treatment settings. In whatever form it is found, however, fraud in these health care financing programs adversely impacts on all Americans. It cheats taxpayers who must ultimately bear the financial burden of misuse of funds in any government-sponsored program. It diverts from those most in need, the nation's elderly and poor, scarce program dollars that were intended to provide vitally needed quality health services. The wasting of program funds through fraud also further erodes the financial stability of those state and local governments whose budgets are already overextended and who must commit an ever-increasing portion of their financial resources to fulfill the obligations of their medical assistance programs. In addition to these adverse financial consequences, the activities of those who seek to defraud these programs unfairly call into question and honesty and integrity of the vast majority of practitioners and health care institutions.

Fraud and abuse can occur in a number of different medical settings. Recent investigations have demonstrated the pervasiveness of the problem.

A. SHARED HEALTH FACILITIES

Many of the more flagrant examples of fraud and abuse activities have been uncovered in so-called "shared health facilities," also referred to as medicaid "mills." Typically, these are unregulated, unlicensed, and poorly equipped storefront units located in ghetto areas of large metropolitan cities. Such mills derive their primary business from welfare patients.

Owners of these facilities are usually individuals who have joined together in a partnership or corporation arrangement. Some may own more than one facility. Some may also be providers on the facility premises or at another location. They may also own pharmacies or laboratories which are often used as the exclusive lab or pharmacy service by all practitioners in the facilities. In certain instances there is overlapping ownership between medicaid mills and factoring companies.

Many medicaid practitioners in urban areas, with little working capital and often holding foreign medical degrees, turn to medicaid mills. These are usually owned by real estate operators who have sufficient capital to purchase the land, office space, and equipment necessary to operate a medical practice. In turn, the average practitioner will pay from 30 to 40 percent of gross income as rent, will lose 12 percent of his income to the factoring agency, and in a large number of cases be asked to divide the remaining net 50–50 with the mill owner. In some mills, the practitioners' total medicaid income is turned over to the mill operator and the practitioner receives a commission based on dollar volume (an average of 20 to 40 percent to the practitioner and 60 to 80 percent to the mill operator).

The most common violations in the mills include:

(1) "ping-ponging"—referring of patients from one practioner to another within the facility even though there is no medical reason for doing so;

(2) "ganging"—billing for multiple services to realtives who accompany a family member who alone had sought treatment at the mill;

(3) "upgrading"—billing for a service more extensive than that actually provided;

(4) "steering"—directing a patient to a particular pharmacy, a violation of the medicaid program's policy of freedom of choice; and

(5) billing for services not rendered—either adding services not performed onto an invoice carrying legitimate billings or submitting a totally fraudulent claim.

Other violations include soliciting offering, or receiving kickbacks; billing twice or more for the same service; and billing both medicare and medicaid for the same service.

Fee splitting and percentage lease arrangements are common practices and often go hand-in-hand with medicaid mills. Percentage lease arrangements are a basic economic incentive to form these facilities. Percentage lease arrangements give the landlord a percentage of the provider's gross income in return for office, space, equipment, shared waiting rooms, laboratory services, custodial and office help, and often administrative services. Studies have shown that the average percentage lease in New York City, for example, appeared to range from 30 to 40 percent of the providers' gross fees for most medical disciplines. While the American Medical Association has ruled this practice unethical, it is not considered illegal in most States and is not prohibited under Federal law or regulations.

Factoring is also a very common practice associated with medicaid mills. Although factoring was outlawed under the Social Security Amendments of 1972, factoring firms have evaded statutory intent by working under a power of attorney arrangement.

B. CLINICAL LABORATORIES

Both medicare and medicaid provide coverage for laboratory services provided by independent clinical laboratories. Over the past several years, there has been increasing concern over the potential for fraud and abuse among clinical laboratories, particularly for services funded by the medicaid program. Several State commissions and legislative investigative committees have focused attention on this issue. At the Federal level, two congressional committees and the General Accounting Office have also examined service and billing patterns in these facilities.

The House Committee on Interstate and Foreign Commerce reviewed the question of fraud and abuse in clinical laboratories within the context of overall improvements needed in such facilities. Testimony presented to the committee by the executive director of the New Jersey State Commission of Investigation indicated that physicians often determined which laboratories would do the test work for their medicaid patients by the amount of the kickbacks and rebates offered by the laboratory. Testimony before the committee's Subcommittee on Oversight and Investigations indicated that these kickbacks are in the neighborhood of 25 percent.

Kickbacks take a number of forms including cash, long-term credit arrangements, gifts, supplies and equipment, and the furnishing of business machines. The most common practice, however, involves the "rental" of small office space in a medical clinic for amounts which are far in excess of the reasonable value of the space. Frequently, the "rent" is determined by paying a percentage of the business sent to the laboratory, often in amounts as high as 30 to 45 percent of the medicaid billings of the physician or clinic sent to the laboratory.

C. NURSING HOMES

Nursing home fraud and abuse has also been the subject of extensive study and investigation. Numerous reports and hearings have been published by congressional committees, Federal agencies, and State commissions which document such activities as patient abuse, substandard homes, deceptive real estate practices, false cost reporting, and kickback practices.

Fraudulent and abusive practices relating to program costs involve the intentional misrepresentation or falsification of the costs involved in providing patient care. These practices may take many forms. Examples include: deceptive real estate practices which artificially inflate property costs, false or misleading cost reports which hide nonallowable costs, inadequate accounting procedures which prohibit effective auditing, kickbacks from vendors, and failure to disclose ownership interests. Among other questionable activities engaged in by some nursing home owners and operators are:

(1) *Deceptive non-arms-length transactions.*—Increased medicaid reimbursement can result from failure to disclose a "non-arms-length transaction" for services, realty or goods provided to the nursing home. This type of transaction is defined as an arrangement in which the nursing home operator has at least a 10 percent interest in the equity of a company providing real property, goods, or services to the facility.

(2) *Reporting other business expenses on the nursing home's books.*—Some nursing home owners attempt to put the expense of other business interests on the nursing home's records. These include real estate taxes, maintenance supplies, and insurance and fuel expenses.

(3) *Unauditable books.*—The books of some nursing homes are practically unauditable. A case was reported where an owner kept one set of books for three of his homes with records so jumbled that according to the State auditor "they defied all ordinary auditing procedures."

D. INDEPENDENT PRACTITIONERS

An independent practitioner's income from medicaid and medicare is based in part on the volume and complexity of the services he provides. Thus, for the practitioner, program fraud and abuse covers a broad spectrum of practices, ranging from the rendering of services of arguable medical necessity to such criminal offenses as filing false claims.

There is much less evidence of fraud and abuse among practitioners than by nursing homes, medicaid mills, and independent laboratories. However, there is no way to estimate the extent to which fraud and abuse by practitioners has gone undetected. Much of the evidence that has been collected in these other areas has been based on the testimony of associates, a review of business records, and other investigative techniques that are impractical or less suitable for the review of an individual practitioner's activities. Detection and proof of fraud or abuse by an individual practitioner must often depend on the patient, who may well be both old and sick, and without medical knowledge. In any case, whatever its true extent might be, it is clear that the potential for exploitation exists for those practitioners that choose to cheat medicaid and medicare.

Perhaps the most flagrant fraud involves billings for patients whom the practitioner has not treated. A related form of fraud involves claims for services to a practitioner's patients that were not actually furnished and intentionally billing more than once for the same service.

Furnishing excessive services is probably the most costly noncriminal abuse faced by health benefit programs. At the same time, it is relatively difficult to prove and correct. Since the medical needs of a particular patient can be highly judgmental, it is difficult to identify program abuse as a practical manner unless the overutilization is grossly unreasonable.

H.R. 3 is designed to strengthen the ability of the Federal and State governments to find and correct abuse and to detect and prosecute fraud. Fraud involves an intentional deception or misrepresentation, with the intent of receiving some unauthorized benefit for the individual engaged in fraud. In the health area, examples of fraud may include: billing for services not rendered, misrepresentation of services rendered, kickbacks, deliberate duplicate billing, false or misleading entries on cost reports, and so forth. Program abuse is less clearly defined and includes activity wherein providers, practitioners, and suppliers of services operate in a manner inconsistent with accepted, sound medical or business practices resulting in excessive and unreasonable financial cost to either medicare or medicaid. Included in the area of abuse are the provision of unnecessary health services and the provision of necessary care in unnecessarily costly settings.

To deal with the problem of fraud, more effective prosecution efforts and stiffer criminal penalties are proposed. Additionally, since issues of medical necessity and quality of care may be present in cases of possible program abuse (as distinct from criminal fraud), PSRO's can be a valuable resource for the exercise of the professional medical judgment that may need to be made in certain of such cases. The committee believes that every effort must be made to encourage the rapid implementation of the PSRO program. To achieve this end, H.R. 3 includes several provisions making modifications in the administrative structure of the program to enhance the capacity of individual PSRO's to effectively review matters of quality and necessity.

V. Committee Proposal

EXPLANATION, JUSTIFICATION, AND COMPARISON WITH PRESENT LAW

Prohibition Against Assignment by Physicians and Others of Claims for Services; Claims Payment Procedures for Medicaid Program (Section 2)

The Committee's bill would modify existing law to preclude the use of a power of attorney as a device to circumvent the existing ban on the use of "factoring" arrangements in connection with the payment of claims by the medicare and medicaid programs. The bill further requires State medicaid programs to provide for timely claims payment procedures and provides higher Federal matching funds for a three-year period to assist States with programs of educational and technical assistance to expedite the filing and payment of claims.

In 1972, the Congress took action to stop a practice under which some physicians and other persons providing services under medicare and medicaid reassigned their medicare and medicaid receivables to other organizations or groups. Under the conditions of these reassignments, the organizations or groups purchased the receivables for a percentage of their face value, submitted claims and received payments in their name. By 1972, it had become apparent that such reassignments were a significant source of incorrect and inflated claims for services paid by medicare and medicaid. In addition, cases of fraudulent billings by collection agencies and substantial overpayments to these so-called "factoring" agencies were also found.

Congress concluded that such arrangements were not in the best interest of the government or the beneficiaries served by the medicare and medicaid programs. The Social Security Amendments of 1972, Public Law 92–603, therefore, included a prohibition against the payment for covered services to anyone other than the patient, his physician, or other person who provided the service, unless the physician or other person is required as a condition of his employment to turn his fees over to his employer, or unless the physician or other person has an arrangement with a facility under which the facility bills for such services.

Despite these efforts to stop factoring of medicare and medicaid bills, some practitioners and other persons have circumvented the intent of the law by use of a power of attorney. The use of a power of attorney allows the factoring company to receive the medicare or medicaid payment in the name of the physician, thus allowing the continuation of program abuses which factoring activities were shown to produce in the past.

The bill would modify existing law to preclude the use of a power of attorney as a device for reassignments of benefits under medicare and medicaid, other than an assignment to a governmental entity or establishment, or an assignment established by or pursuant to the order of a court of competent jurisdiction. The bill also provides for similar prohibitions with respect to billings for care provided by institutions under medicare and medicaid. However, it would not preclude the agent of a physician or other person furnishing services from collecting any medicare or medicaid payment on behalf of a physician, provided the agency does so pursuant to an agreement under which the compensation paid the agency for his services or for the billings or collections of payments is unrelated (directly or indirectly) to the dollar amount of the billings or payments, and is not dependent upon the actual collection of any such payments. Thus, the use of billing agents by doctors and others, when the agents are paid on a basis related to the cost of doing business and not dollar amounts billed or collected, would not be precluded. The bill would not impose any limitations on the use of billing or collection agencies for payments owed by anyone other than the medicare or medicaid programs. Nor is it the committee's intention that this provision preclude the legitimate transfer of accounts receivable from these programs by an individual or an institution upon the "sale" of the individual's practice (for example upon retirement) or as part of the sale of all the assets of an institution.

The committee received considerable testimony indicating that undue delay in medicaid claims payments contributes to the rise of factoring arrangements as well as discourages physicians from participating in the program. The committee wishes to assure that the ban on factoring arrangements will not impose an undue hardship on medicaid practitioners. The bill therefore requires State medicaid plans to provide for claims payment procedures which ensure that 90 percent of claims for services furnished by health care practitioners through individual or group practices or through shared health facilities are paid within 30 days of receipt; 99 percent of such claims must be paid within 60 days of receipt. State plans must further provide for procedures for prepayment and postpayment claims review. The bill permits the Secretary of Health, Education, and Welfare to waive this

State plan requirement if he finds that a State has exercised good faith in trying to ensure timeliness and accuracy in its claims payment operation. Among other things the Secretary should take into account in making a waiver determination is whether the State has received an unusually high volume of claims which are not clean claims (i.e., claims for which no further written information or substantiation is required from the provider).

In many areas of the country, a significant volume of medicaid claims submitted are inadequately or incorrectly filed. The bill therefore authorizes 90 percent Federal matching from January 1978 through September 1980 for the costs attributable to the conduct of such educational and technical assistance programs for health care practitioners as the Secretary determines are likely to expedite the filing and payment of claims. Technical assistance may be provided through such means, including outreach offices, the media, and telephone systems, as the Secretary determines to be appropriate. The maximum amount of payment available to the States under this section may not exceed $1.25 million in any calendar quarter. If the aggregate amount of payment would otherwise exceed this limitation, the amount made available to each State would be proportionately reduced.

Disclosure of Ownership and Financial Information (Section 3)

The Committee's bill would require entities (other than individual practitioners or groups of practitioners) providing services under medicare, medicaid, or the maternal and child health program to disclose certain ownership interests, as a condition of program participation. These discolsure requirements would also be applied to medicare intermediaries and carriers and medicaid fiscal agents. Disclosure of additional ownership and financial information would be required, but only when specifically requested.

Current law and program policies already require the provision of certain ownership and financial information pertaining to entities providing services under medicare and medicaid. For example, an agreement with a provider of services under medicare may be terminated if the provider fails to furnish information necessary to validate the amount of payment claimed. In a different context, present law requires, as a medicare and medicaid condition of participation, a skilled nursing facility to disclose to the Secretary or appropriate State agency, and keep current, the name of anyone having significant ownership interest in the facility. Intermediate care facilities under medicaid are also required to disclose information on significant ownership interests.

The Committee believes, however, that the information required under current law is often insufficient to facilitate the detection of fraudulent practices. Information now required does not provide adequate documentation on persons with significant ownership interests in more than one facility or other entity participating in medicare, medicaid, or the maternal and child health program. Information is not specifically required to identify persons with significant ownership interests in related companies that supply goods and services to providers or other participating entities. Authority to obtain information on financial transactions with related suppliers or with subcontractors is not clearly defined in law.

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To remedy these problems, the bill would require disclosure of specified ownership information to the Secretary or the appropriate State agency, as a condition of an entity's participation, certification, or recertification under medicare, medicaid, or the maternal and child health program. Entities required to disclose would be defined as: Medicare providers of services (as defined in section 1861(u), which includes hospitals, skilled nursing facilities, and home health agencies), independent clinical laboratories, renal disease facilities, and all entities (other than individual practitioners or groups of practitioners) that claim reimbursement for services provided under medicaid or the maternal and child health program. In addition, the bill would require medicare intermediaries and carriers and medicaid fiscal agents to disclose specified ownership information as a condition of contract or agreement approval or renewal under titles XVIII and XIX.

The bill specifies that disclosing entities must supply full and complete information as to the identity of each person who:

(1) has a direct or indirect ownership interest of five percent or more in the entity,

(2) owns (in whole or part) a five percent interest in any mortgage secured by the entity,

(3) is an officer or director of the entity, if it is organized as a corporation, and

(4) is a partner in the entity, if it is organized as a partnership.

Where disclosing entities providing services under medicare or medicaid own five percent or more of a subcontractor, similar ownership information would be required to be disclosed about the subcontractor.

In addition, the bill would require, to the extent feasible, that information about a person's ownership disclosed by an entity must also include information with respect to ownership interest of that person in any other entity which is required to comply with disclosure requirements under the bill.

The bill would also modify the existing provisions of title XVIII and XIX which relate to termination of medicare provider agreements or suspension of medicaid payments to health care entities (other than individual practitioners and groups of individual practitioners) by adding two additional requirements. The bill would require a provider entity to comply with specific requests addressed to it by the Secretary or the State medicaid agency for full and complete information on: (1) the ownership of any subcontractor (as defined in regulations) with whom the provider has annual business transactions of more than $25,000, and (2) any significant business transactions (as defined in regulations) between it and any subcontractor or between it and any wholly-owned supplier.

In developing regulations to define subcontractors and suppliers, the Committee intends that a distinction be made between agencies and organizations from which a provider only purchases goods and services to assist it in meeting its obligations to patients and those agencies and organizations to which a provider has actually delegated some of the duties and obligations it has directly to its patients. Although the facts and circumstances of individual situations may differ, it is contemplated under such a delineation that the relationship between a hospital and a commercial laundry would be considered to be that of a provider and its supplier, but that the relationship between a hospital and a management company with which it has contracted to administer either all or part of the day-to-day operations of the institution or the relationship between a hospital and an independent radiological service would be that of a provider and a subcontractor.

The bill specifies that the Secretary is to determine by regulation the meaning of the phrase "directly or indirectly" with respect to persons having ownership interests in disclosing entities. In directing him to do this, the Committee is acutely aware of the difficulties involved in developing this definition, particularly when the phrase "persons with ownership interests" is interpreted to mean a corporation. Institutional providers of health care often are owned by corporate entities which in turn are owned by other corporations. In order to compile accurate information on persons with ownership interests in disclosing entities, the Committee believes it is also necessary to obtain information on persons with ownership interests in these other corporations. The information to be disclosed under the bill must go beyond the listing of corporate identities unless that corporation is already subject to ownership disclosure under the statutes administered by the Securities and Exchange Commission or other Federal regulatory agencies. It is intended, at the minimum, to identify those persons with ownership interests of five percent or more in a nonpublicly held corporation that owns a disclosing entity. In addition, the Secretary may determine that it is necessary to require disclosure of persons with ownership interests in nonpublicly held corporations beyond the first level of corporate ownership where the concept of "pyramiding" of corporate structures appears to be present.

The committee views the disclosure requirements imposed by the bill to be of critical importance in the process of detecting and deterring fraudulent and abusive practices within the medicare, medicaid, and the maternal and child health programs. The Committee does not intend, however, or these requirements to be unduly burdensome on providers and other entities to which they apply. The provisions were designed to be incorporated into the ongoing certification or contractual process. It is, therefore, expected that their implementation and administration will be accomplished in such a way as to preclude unnecessary additional administrative burdens on those complying with them.

Penalties for Defrauding Medicare and Medicaid (Section 4)

The committee bill would modify the penalty provisions in existing law which relate to those persons providing services under medicare and medicaid.

Existing law provides specific penalties under the medicare and medicaid programs for certain practices that have long been regarded by professional organizations as unethical, which are unlawful in some jurisdictions, and which contribute significantly to the cost of the programs. Such practices as the submission of false claims, or the soliciting, offering, or acceptance of kickbacks or bribes, including rebates or a portion of fees or charges for patient referrals, are misdemeanors under present law and punishable by a maximum $10,000 fine, up to one year imprisonment, or both. In addition, the making of false statements with respect to material facts concerning the conditions of health care facilities in order to qualify for certification under medicare and medicaid is considered a misdemeanor and punishable by a maximum $2,000 fine, up to six months in prison, or both.

Recent hearings and reports, however, indicate that such penalties have not proved adequate deterrents against illegal practices by some individuals who provide services under medicare and medicaid. In addition, these misdemeanor penalties appear inconsistent with existing Federal criminal code sanctions which make similar actions punishable as felonies. Also, it has been brought to the attention of the committee by U.S. Attorneys' offices which have utilized these Social Security Act sanctions in the prosecution of medicare and medicaid fraud cases that the existing language of these penalty statutes is unclear and needs clarification.

The bill would strengthen the penalty provisions in existing law which relate to persons providing services under medicare and medicaid. Most fraudulent acts now classified as misdemeanors would become felonies. Penalties for these acts would be increased to a maximum $25,000 fine, up to five years imprisonment or both.

In addition, the bill would clarify and restructure those provisions in existing law which define the types of financial arrangements and conduct to be classified as illegal under medicare and medicaid.

It would make subject to the penalty provisions any person who solicits or receives any remuneration (1) in return for referring an individual to a person for the furnishing, or arranging for the furnishing of items or services; or (2) in return for purchasing, leasing, or ordering, or arranging for, or recommending the purchasing, leasing, or ordering of goods, facilities, or services. Also, any person who offers or pays any remuneration to any person to induce such person to do similar activities would be subject to the penalty provisions.

The bill would define the term "any remuneration" broadly to encompass kickbacks, bribes, or rebates which may be made directly or indirectly, overtly or covertly, in cash or in kind (but would exclude any amount paid by an employer to an employee for employment in the provision of covered items or services).

The bill would specifically exclude the practice of discounting or other reductions in price from the range of financial transactions to be considered illegal under medicare and medicaid, but only if such discounts are properly disclosed and reflected in the cost for which reimbursement could be claimed. The committee included this provision to ensure that the practice of discounting the normal course of business transactions would not be deemed illegal. In fact, the committee would encourage providers to seek discounts as a good business practice which results in savings to medicare and medicaid program costs.

In addition, the committee bill would allow States to suspend, for a period not to exceed one year, the eligibility of medicaid recipients convicted of defrauding the program. However, the misdemeanor penalty provision presently provided under existing law for conviction of such individuals would be retained (maximum fine of $10,000, up to one year imprisonment, or both) as would be the penalty for conviction of a beneficiary under the medicare program.

In its consideration of this bill, the committee has focused considerable attention on the activities of the Department of Justice to investigate and prosecute fraud in the medicare and medicaid programs. The committee believes that the Department must develop the resources to combat this complex type of criminal activity. The Attorney General has made a commitment to strengthen departmental efforts in this area and intends to monitor those efforts quite closely. The letter of the Attorney General to the Chairman of the Health Subcommittee of the Ways and Means Committee outlining departmental initiatives in this area follows:

OFFICE OF THE ATTORNEY GENERAL,
Washington, D.C., May 12, 1977.

Hon. DAN ROSTENKOWSKI,
Chairman, Subcommittee on Health, Committee on Ways and Means, House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: I am writing you again with refernce to the proposal to include in H.R. 3 a mandate for the establishment of a separate and identifiable organizational unit within the Department's Criminal Division to carry out specified functions relating to investigation and prosecution of criminal violations in the programs of health insurance and medical assistance provided under the Social Security Act. As I indicated in my appearance before your Subcommittee, I fully concur in the need for vigorous investigation and prosecutions of fradulent activities in the medicare-medicaid program. I strongly feel, however, that the aforementioned provision is unnecessary and would set an undesirable precedent by dictating in law a particular subordinate organization within the Criminal Division.

In recognition of the importance of taking effective action against medicare-medicaid abuses, we are currently taking the following steps.

1. We have within the Fraud Section of the Criminal Division a program fraud unit which coordinates Department efforts directed against program abuse and maintains regular liaison with program agencies including HEW.

2. We are currently working on preparation of a Medicaid Enforcement Manual for distribution to Assistant United States Attorneys to assist them in prosecuting medicaid-medicare cases.

3. We are meeting on a regular basis with the Inspector General and his staff of HEW in an attempt to develop strategies and enforcement priorities within medicaid-medicare areas.

4. There is a separate program fraud unit within the Public Integrity Section which focuses on situations involving corruption of government officials in the administration of programs.

5. We are attempting to identify significant cases in order to insure that ample resources are devoted to their development and prosecution.

6. Many of the larger of the United States Attorneys offices, including the Southern District of New York and Chicago, have established separate program fraud units within the district to focus on these types of offenses.

I have every intention of continuing emphasis in this area. I do respectfully recommend, however, against placing in the law the requirement of a specific organization entity for this purpose. I am afraid that other Congressional committees will feel that they must support similar organizational requirements in law for their programs to insure that such programs receive appropriate attention. A proliferation of special units would inevitably lead to confusion, lack of flexibility and be self-defeating of the purposes intended.

Sincerely,

GRIFFIN B. BELL, *Attorney General.*

In addition the bill modifies section 204(a) of Public Law 94–505, relating to the annual reports of the Health, Education and Welfare Inspector General, to require the Inspector General's report to include an evaluation of the performance of the Attorney General in the investigation and prosecuting of criminal violations relating to fraud in the medicare and medicaid programs and include any recommendations with respect to improving the performance of such activities.

Amendments Related to Professional Standards Review Organizations (Section 5)

Waiver of Other Review Requirements (Section 5(a))

The committee's bill provides that where the Secretary finds a given Professional Standards Review Organization (PSRO) competent to perform required review functions, similar activities otherwise required by law would not apply, except to the extent specified by the Secretary.

Under present law, the Secretary is authorized to waive any or all of the review, certification, or similar activities otherwise required under the law where he finds, on the basis of substantial evidence of the effective performance of review and control activities by PSRO's, that the activity or activities are no longer needed for the provision of adequate review and control. The purpose of this provision was to avoid duplication of review functions. Current law does not specifically state that the waiver authority is applicable to conditionally designated organizations, although the language has been interpreted to permit such actions.

The bill would both clarify present law and simplify its application by providing that where the Secretary makes a formal determination that a given PSRO is competent to perform required review functions, the review, certification and similar activities otherwise required by law would not be applicable with respect to those providers, suppliers, and practitioners being reviewed by such PSRO, except to the extent specified by the Secretary. A finding by the Secretary under this subsection could be made both with respect to conditionally designated and qualified PSRO's. The provision would not affect other provisions of existing law relating to determinations with respect to conditions for eligibility to or payment of benefits (as distinct from reviews or certifications of medical necessity).

Modification of Requirements for Conditionally Designated PSRO's (Section 5(b))

The committee's bill extends the time period for conditional designation of PSRO's and clarifies the language of present law pertaining to the duties and functions a PSRO must assume during this trial period.

Current law provides that each PSRO shall initially be designated on a trial basis for a period not to exceed two years. By the end of the period, the organization shall be considered a qualified organization only if the Secretary finds that it is substantially carrying out in a satisfactory manner the functions required of a PSRO with respect to institutional services in its area. When the legislation was enacted, it was anticipated that conditionally designated organizations would be able to assume review responsibilities with respect to all institutional services within a two-year period. Implementation of the program has been slower than anticipated with the major focus to date on review of inpatient hospital services. A number of conditionally designated organizations have or are approaching the end of their two-year trial period. While many are effectively performing reviews of services, they are technically not eligible for continuation of their conditional status or designation as qualified organizations.

The bill modifies the conditional designation provision of present law to provide for a conditional period not to exceed 48 months. The Secretary would be authorized to extend this period for an additional 24 months if an organization has, for reasons beyond its control, been unable to satisfactorily perform all of its required functions. The committee expects that this extension of the conditional period would be authorized only in unusual circumstances.

The bill also clarifies the requirement of present law that PSRO's must assume responsibility for review of all institutional services (including ancillary services) during the conditional period. Additionally, the bill clarifies the requirement that PSRO's must be reviewing long-term institutional care services (subject to the provisions of section 5(d) which leave the responsibility for review of services in intermediate care facilities with the State medicaid agency unless the Secretary finds the State is not performing effective review).

Review Requirements (Section 5(c))

The committee's bill requires the Secretary to give priority to PSRO requests to review services provided in "shared health facilities"; mandates the development of ambulatory care review methodologies for use by PSRO's; requires a PSRO to undertake ambulatory care review not later than two years after it has achieved operational status; and modifies the language in current law pertaining to physicians excluded from participation in review activities.

Under current law, a PSRO is required to review only care provided by or in institutions. It may request authority to review other kinds of health services, and the Secretary may approve the request at his option. To date, little emphasis has been given to the assumption of review responsibility by PSRO's for other kinds of health care services.

The bill would require the Secretary to give priority to requests by PSRO's to review services in "shared health facilities" with the highest priority being assigned to requests from PSRO's located in areas with substantial numbers of such facilities. A "shared health facility" is defined as an arrangement meeting all of the following criteria:

(1) Two or more practitioners practice their professions at a common physical location;

(2) The practitioners share common space, services of supporting staff or equipment;

(3) The practitioners have a person (who may himself be a practitioner), paid on a percentage or other basis clearly unrelated

to the value of the services provided, who either is in charge of or supervises substantial aspects of the operation or who makes available services of supporting staff who are not employees of such practitioners; and

(4) At least one of the practitioners receives from medicare, medicaid, and maternal and child health fee-for-service payments in excess of $5,000 for one month or $40,000 for 12 months.

The term "shared health facility" specifically excludes hospitals, skilled nursing facilities, home health agencies, federally approved health maintenance organizations, hospital cooperative shared services organizations meeting the requirements of section 501(e) of the Internal Revenue Code, or any public entities.

The definition of a "shared health facility" is designed to distinguish those types of ambulatory facilities (sometimes referred to as "Medicaid Mills") which are characterized by a high volume of services to medicaid patients (often of an excessive or unnecessary nature), and the payment of a percentage of the medicare and medicaid billings to the owner or manager of the facility, from legitimate group practice arrangements under which several practitioners render services at a common location. Since a shared health facility could evade the test of percentage arrangements, the Secretary has leeway to determine whether the payments to the owner or manager, while technically not a percentage of billings, are clearly unrelated to the value of the services provided by such person to the facility. By requiring a facility to meet all four criteria specified in the bill, it is expected that such legitimate arrangements among practitioners would be excluded from the definition. The Committee expects, therefore, that the Department will exercise judgment in applying this definition so as to assure that legitimate group practice arrangements are not inappropriately classified.

Recent congressional hearings and reports have documented widespread instances of fraud and abuse in certain types of ambulatory facilities which have come to be known as "Medicaid Mills." The definition of shared health facilities is designed to identify these specific types of arrangements in order to facilitate PSRO review of the services furnished by such facilities. Committee wishes to emphasize that a PSRO is not a fraud detection organization; its role is to render professional determinations as to the medical necessity and appropriateness of services. Thus, a PSRO will be expected, where it chooses to undertake review of services furnished by "shared health facilities," to review those services for the same purposes—to judge appropriateness and quality—that it would review services provided in other health care settings.

Under current law, PSRO's may request authority review ambulatory care services, i.e., those provided in clinics or doctors' offices. However, the committee notes that reliable ambulatory care review methodologies have not as yet been developed. The bill, therefore, requires the Secretary to develop, within two years, effective ambulatory care review methodologies for use by PSRO's. The bill further directs the Secretary, where he finds a PSRO capable of undertaking ambulatory care review, to require the organization to undertake such review not later than two years after it has achieved operational status. The Committee expects that in implementing this requirement, the Secretary will exercise judgment with respect to the varying capacities of PSRO's and, where appropriate, will establish a reasonable classification of ambulatory care review activities for an organization to undertake. Such classification might include specific categories of services or specific aspects of various service categories. The committee further notes that "ambulatory care services" are those services not rendered by or in an institution. Institutional review, including review of services provided in hospital outpatient departments or emergency rooms, is a requirement of current law and must be conducted before an organization can achieve operational status.

Under current PSRO review provisions, a physician is precluded from reviewing health services provided to a patient if he was directly or indirectly involved in providing the services. Present law further precludes review by a physician of services furnished in any institution, organization, or agency if he or any member of his family has, directly or indirectly, any financial interest in such entity.

The bill would modify these restrictions to permit greater opportunity for physicians participation in PSRO review activities. Under the bill, a physician would not be permitted to review services for which he was directly responsible (rather than directly or indirectly responsible as in present law) or services in an institution in which he or a member of his family has a "significant" financial interest (rather than "any" financial interest, as in present law.) The committee expects that in implementing this provision, HEW will employ the same definition of "significant" financial interest as is currently used in administering medicare.

The bill further provides that arrangements with PSRO's for reimbursement of the costs of review activities are to be made in a manner similar to that provided for medicare intermediaries (which includes provision for advances of funds and payment of administrative costs).

Conclusive Determinations for Payment (*Section 5(d)*)

The committee's bill provides that where a PSRO has been found competent by the Secretary and is performing specific review functions, medical determinations made in connection with such review shall be considered conclusive on those issues for purposes of payment. The bill provides a formal role for the States in the process of establishing and evaluating PSRO review of services provided through the medicaid program. The bill also precludes delegated review in skilled nursing facilities and provides that review of intermediate care facility services will be undertaken by a PSRO only if the Secretary finds that the State is not performing effective review in these facilities.

Under present law, medicare payments and the Federal share of medicaid payments may not generally be made for health care services which a PSRO, in the proper exercise of its duties, has determined to be medically unnecessary or inappropriate. However, the committee believes that it is necessary, in order to avoid the performance of disruptive duplicative reviews by medicare and medicaid agencies, to clarify the scope of the PSRO's authority and the role of the medicaid State agencies.

Accordingly, the bill provides that where a conditionally designed or a qualified PSRO has been found competent by the Secretary to assume specific review responsibilities and is performing such reviews, a determination as to quality or necessity made in connection with such review would constitute the conclusive determination on those issues for purposes of payment. (Such determinations would be subject to the hearings and appeals provisions of present law.) Medicare fiscal intermediaries and State medicaid agencies would continue to be responsible for other types of reviews and determinations relating to program eligibility, coverage of services, audit, claims payment, fraud and abuse detection, and related activities.

The committee has received comments from a number of States expressing concern over the potential impact of PSRO determinations on State medicaid budgets. The committee has concluded that since substantial State monies are involved it is appropriate that they be given an opportunity to evaluate a PSRO's capability to efficiently and effectively perform review of medicaid services. The bill, therefore, makes provision for the participation of States in the PSRO designation process and in the ongoing monitoring of PSRO review activities.

The bill requires a PSRO to consult with the medicaid State agency in the development of its formal review plan (required as a condition for designation) and in any modification of the plan involving assumption of review responsibility for additional categories of services. The bill provides the States with an opportunity to review and comment on the proposed conditional designation of a PSRO, the change in designation status from conditional to operational, and the assumption by the PSRO of responsibility for long-term care and ambulatory care review. Before the Secretary designates a PSRO or substantially adds to its functions, he is required to take the State's views into account. If his decision differs from the course recommended by the State, he must notify the State of the reason for his decision and allow them additional time to provide further support for their views.

The bill provides that a PSRO's determination shall constitute a conclusive determination for purposes of payment under medicaid only if the PSRO has entered into a memorandum of understanding (approved by the Secretary) with the appropriate State medicaid agency. The purpose of this memorandum is to delineate the relationship between the PSRO and the State agency. The requirement for a memorandum of understanding may be waived only if the State indicates that it does not wish to enter into such an understanding or if the Secretary finds that the State agency has refused to negotiate in good faith or in a timely manner with the PSRO involved.

A State medicaid agency may request a PSRO to include in its memorandum of understanding a specification of review goals and methods (in addition to those required in the PSRO's formal review plan) for the performance of its required functions. If the State medicaid agency and the PSRO are unable to agree on the inclusion of such items, the Secretary would review the requested specification and require that it be included in the memorandum if he determines that the review goals and methods are consistent with titles XI and XIX of the act and do not impair the effectiveness and uniformity of the PSRO's review of health care services under medicare and medicaid. For example, a State might request that a PSRO emphasize the prevention of unnecessary Friday admissions of medicaid patients for elective procedures not scheduled to be performed until Monday. Your committee notes that the PSRO's application of norms, criteria, and standards would not be affected by this provision; standards for quality, appropriateness and necessity of services would continue to be the same for both programs. If the PSRO found review of weekend admissions was appropriate, it would generally be applied to all patients whose care was reviewed by the PSRO.

The committee intends that the Secretary shall not deny a State agency request solely because the PSRO has not ben utilizing such a requested method or goal for the medicare program or because the PSRO cannot apply the method or goal to the medicare program due to defferences in the patient populations. Rather, the Committee intends that where differences in the patient populations do not preclude uniform review by the PSRO, the Secretary's decision shall be based on his determination as to whether the PSRO can effectively apply such review methods or goals to the review of services provided under both the medicare and medicaid programs in order to ensure that the uniformity of PSRO review under the Social Security Act can be maintained.

The committee intends that any review specified by the State agency which the PSRO performs in accordance with its memorandum of understanding with the agency and pursuant to its review authority until title XI would be fully federally funded. In addition, the bill provides regular Federal matching if a medicaid State agency contracts with a PSRO to undertake additional review responsibilities, provided the State agency formally requests it and the performance of such responsibilities is provided for in an approved medicaid plan amendment. For example, the State agency may request the PSRO to approve so-called administrative days, such as an additional day of hospital stay which may be required because there is no immediately available skilled nursing facility bed.

The bill also provides Federal financial participation to State medicaid agencies for the costs of monitoring the performance of review activities by PSRO's under State monitoring plans which have been approved by the Secretary. It is expected that the Secretary will develop criteria for approval of such plans and that they will not be approved where the proposed monitoring activities duplicate the purposes of PSRO review. The State medicaid agency may include in its plans for monitoring a specification of the performance criteria for judging PSRO effectiveness. Inclusion of such specifications in the State's monitoring plan is not mandated because it is believed that most States during the development and initial implementation of State monitoring of PSRO review will not have such performance criteria developed. However, at such time as the State agency intends to utilize performance criteria for judging PSRO review effectiveness, the Committee expects the agency to discuss the criteria with the PSRO and to amend the State's monitoring plan to include the agreed-upon criteria.

The bill authorizes the State agency to request suspension of the PSRO's authority to make conclusive determinations if in the course of its monitoring activities it develops reasonable documentation that the PSRO review determinations have caused an unreasonable and detrimental impact either on total State medicaid expenditures or on the quality of care. Within thirty days of receipt of the documentation the Secretary is required to suspend all or part of the PSRO's conclusive determination authority under medicaid. (For example, he may suspend their review of long-term care services, but not hospital services. He may also take similar action with respect to PSRO determinations under medicare if he determines such action is appropriate.) During the suspension period the Secretary is required to conduct a reevaluation of the PSRO's capability to perform review activities and to inform the appropriate agencies, organizations, and congressional committees of any documentation submitted and actions taken.

The bill requires the Secretary to establish procedures and mechanisms governing his relationship to State agencies in connection with their respective responsibilities concerning memoranda of understanding, monitoring, and reevaluations. The Secretary is required to periodically consult with representatives of State agencies and PSRO's. Further, the appropriate State medicaid agency is permitted to be represented on any project assesments conducted by the Secretary. The committee intends that the procedures and mechanisms developed by the Setcretary shall promote smooth working relationships between all parties involved and shall involve a minimum of disruption in the orderly implementation of the PSRO program. The committee further intends that State monitoring activities will become less intensive over time (particularly with respect to PSRO's which are no longer in conditional status) and will focus on problem areas which have been detected in the performance of PSRO review.

The committee is aware of the fact that as PSRO's begin to review services provided in institutional settings other than hospitals, different requirements may be appropriate. Accordingly, the bill prohibits delegated review in skilled nursing facilities since these facilities have generally had far less experience in conducting in-house review activities than hospitals.

(Generally, this prohibition against delegated review would apply only to skilled nursing facilities which were not distinct parts of hospitals or other institutions. If an SNF is a part of a hospital which has a delegation of review authority from a PSRO, it would be the Committee's intent that delegation of review for skilled nursing facility services provided in that institution would be allowed).

Further, PSRO review of care in intermediate care facilities and public institutions for the mentally retarded (services which are paid for only under the medicaid program) would only be undertaken where the Secretary determines that the State is not performing effective review of the quality and necessity of services provided in such facilities. If the Secretary does make such a finding, and the PSRO is required to carry out the review, the committee expects that the PSRO would not delegate review to the intermediate care facility, just as they are prohibited from such delegation to skilled nursing facilities.

Clarification of Sanctions Provision (*Section 5(e)*)

Current law specifies those conditions under which the Secretary may, at the recommendation of a PSRO, withdraw a medical care provider's eligibility to participate in Social Security Act medical care programs where it is determined that it is not willing, or cannot, carry out its obligations to order and provide only necessary care of acceptable quality.

The bill makes clear that the provision in question applies to any health care practitioner, or any hospital or other health care facility, agency, or organization which is subject to PSRO review.

National Council (Section 5(f))

The bill provides for staggered terms for members of the National Professional Standards Review Council.

Present law provides that the 11 members of the Council shall be appointed for three-year terms and may be eligible for reappointment. The bill would amend this provision. The general term for Council members would continue to be three years, except that for members appointed in 1979, four shall be appointed for a two-year term and three for a one-year term. All members would continue to be eligible for reappointment.

National Council Report (Section 5(g))

Section 5(g) would delete the requirement in present law for an annual report on its activities by the National Professional Standards Review Council and would require instead the submission by the Secretary of a detailed annual report on the PSRO program.

Under the new reporting requirement included in the bill, the Secretary would be required to submit substantially more information concerning the cost and operation of the PSRO program than has previously been required of the National Council. Accordingly, the bill would delete the requirement for the National Council report as duplicative and unnecessary.

Exchange of Data and Information With Other Agencies (Section 5(h))

The committee's bill would expand and clarify the circumstances under which the provision of data or information by PSRO's would not violate the confidentiality requirement of law.

Under present law, any data or information acquired by a PSRO in the exercise of its duties must be held in confidence and may not be disclosed to any person except (1) to the extent that may be necessary to carry out the purpose of the PSRO provisions, or (2) in such cases and under such circumstances as the Secretary shall be regulations provide to assure adequate protection of the rights and interests of patients, health care practitioners, or providers of health care. Interim regulations issued by the Department on December 3, 1976, provide for the disclosure of two types of information acquired by the PSRO:

1. Data and information acquired by the PSRO: (a) which has been published; (b) which has not been identified by the source as confidential; and (c) whose disclosures are not otherwise prohibited by law.
2. Summary statistics aggregated from the Uniform Hospital Discharge Data Set (UHDDS) to the extent that it is not identifiable to an individual patient or health care practitioner.

The bill would expand and clarify those circumstances under which the provision of data or information would not violate the confidentiality provisions to include: (1) provision of data or information by the PSRO, on the basis of its finding as to evidence of fraud or abuse, to Federal or State agencies recognized by the Secretary as having responsibility for the identification or detection of fraud and abuse activities; such data and information may be provided at the request of the recognized agencies at the discretion of the PSRO; and (2) provision of aggregate statistical data to agencies having responsibility for health planning and related activities under Federal or State law. The data and information furnished to the planning agencies would be provided in the format and manner prescribed by the Secretary or agreed upon by the agencies and the PSRO. Such data and information would be in the form of aggregate statistical data on a geographic, institutional, or other basis reflecting the volume and frequency of services furnished and the demographic characteristics of the population whose services are subject to review by the PSRO. However, the data would not identify any individual.

Data and information made available to Federal or State agencies recognized by the Secretary as having responsibility for identifying and investigating fraud and abuse may not be further disclosed except when the disclosure is made in the course of a legal, judicial, or administrative proceeding. Violation of this prohibition would result in application of the penalty specified in existing law.

The committee has included this provision to facilitate the exchange of data and information with other agencies while at the same time assuring that the confidentiality of patient records will not be violated. The committee has received information that PSRO's which have identified suspected cases or widespread patterns of fraud and abuse have been unable to make the information available to enforcement agencies. The committee also notes that the provision of aggregate statistical data to Federal and State planning agencies will enable those bodies to develop a more accurate picture of medical care patterns in their areas, facilitate planning for future resource needs, and prevent unnecessary duplicative data gathering activities.

The bill also includes a provision to protect patient records from subpena or discovery proceedings in a civil suit. This provision, however, would not preclude the subpena or discovery of originals or copies of the same documents in the possession of others.

Legal Expenses (Section 5(i))

The committee's bill provides for payment of legal fees in connection with the defense of suits brought against a PSRO related to the performance of its functions. The bill would authorize the Secretary to assume responsibility for legal fees incurred in connection with the defense of any suit, action, or proceeding brought against the PSRO or any of its members or employees related to the performance of its functions. While all PSRO's currently have liability insurance which covers such attorneys' fees, this provision would serve as an additional guarantee in the event such insurance is subsequently withdrawn.

Payment of PSRO Expenses (Section 5(j))

The committee's bill would clarify the intent of present law that payment for PSRO expenses is to be made from Federal funds.

Under present law, expenses incurred by PSRO's are payable from medicare trust funds and from funds appropriated to carry out the vide for appropriate safeguards against unwarranted inspection or disclosure of such records.

Medical Officers (Section 5(m))

The bill would include medical officers in American Samoa, the Northern Mariana Islands and the Trust Territory of the Pacific Islands in the PSRO program. In these areas medical officers rather than doctors of medicine provide medical care. The bill would therefore permit medical officers licensed to practice medicine in these localities to participate in the PSRO program. These individuals may not, however, serve on the National Council or make any final determinations with respect to medical necessity or appropriateness of care provided by a duly licensed doctor of medicine or osteopathy.

Payment for Review of Part B Services Provided by Hospitals (Section 5(n))

Public Law 94-182, enacted on December 31, 1975, included an amendment to the medicare program which was designed to equalize reimbursement for PSRO hospital review activities whether such review was carried out by a hopsital under delegation from a PSRO or by the PSRO itself. Previously, only delegated review activities could be funded out of the medicare trust funds. Under the new law, PSRO expenses in carrying out nondelegated review for hospital services covered under medicare part A or medicaid or the maternal and child health program would also be reimbursed through this mechanism. The law did not, however, provide for similar funding for PSRO review of hospital services covered under medicare part B.

Accordingly, the bill corrects this oversight by providing that funding for delegated review activities for services provided by a hospital which are covered under medicare part B shall be made from the medicare trust funds.

Statewide Councils (Section 5(o))

The bill extends the protection currently provided to members and employees of a PSRO from criminal prosecution or civil liability when carrying out PSRO functions to members and employees of Statewide Professional Standards Review Councils.

Issuance of Subpenas by the Comptroller General (Section 6)

The bill would give the Comptroller General of the United States the power to sign and issue subpenas to gain information regarding health programs authorized under the Social Security Act.

Currently, the Comptroller General of GAO does not have the statutory authority, under the Social Security Act, to issue subpenas in connection with GAO investigations into health programs authorized by that Act. In a December 29, 1976, letter to the committee, which was in response to an inquiry concerning Social Security Act subpena power for the General Accounting Office, the Acting Comptroller General stated that:

> From the overall perspective, we believe that the subpena power in question would be a useful tool. In all probability, the mere existence of such a power would be sufficient to preclude problems in most cases and, in our opinion, resort to its use would be relatively infrequent. We would thus favor the inclusion of subpena authority in the anticipated new legislation.

The bill would give the Comptroller General of GAO the power to sign and issue subpenas in order to gain information and facilitate review of medicaid, and the maternal and child health programs particularly with respect to investigations of fraudulent and abusive practices. In connection with GAO's statutory functions including investigations, examinations, and auditing, subpenas could be issued to gain access to pertinent books, records, documents, or other information.

Under resistance or refusal by an individual to obey a subpena, the bill would authorize the Comptroller General to request a court order requiring compliance.

In granting GAO the power to subpena books, records, and documents, the committee is aware that the personal medical records of beneficiaries and recipients could be subject to subpena. In the context of the provision, personal medical records are defined to mean any information relating to an individual's medical or mental condition or treatment that is acquired by GAO in the course of its investigations into Social Security Act health programs, in a form that could identify the individual.

The committee strongly believes that confidentiality of personal medical records must be protected and has, therefore, placed strict controls on the disclosure of such information by GAO personnel. The bill would prohibit the disclosure of any personal medical records in the possession of the GAO to any person except those GAO employees whose official duties require seeing them. GAO personnel illegally disclosing such records would be subject to a $1,000 fine, six months imprisonment, or both; and if convicted, prosecution costs. In addition, the bill would exclude the copies of all personal medical records in GAO possession from subpena or discovery proceedings in a civil action. This exclusion, however, would not preclude the subpena or discovery of originals or copies of the same documents in the possession of others.

The bill would permit GAO disclosure of personal medical records only to Federal or State agencies authorized to investigate cases or patterns of fraud and abuse under Social Security Act health programs. Prior to such disclosure, however, the Comptroller General must determine that such records actually reveal evidence of fraud and abuse.

Suspension of Practitioners Convicted of Medicare- or Medicaid-Related Crimes (Section 7)

The committee's bill requires the suspension of physicians or other individual practitioners from participation in medicare or medicaid if such practitioner has been convicted of a program-related criminal offense.

The committee has included this provision in response to the concern that some program violators have been permitted continued participation, often without interruption, in Federal health care programs. The committee feels that misuse of Federal and State funds is a very serious offense and that those convicted of crimes against the programs should not be permitted continued and uninterrupted receipt of Federal and State funds. The committee believes that this threat of suspension, together with the upgraded penalties authorized under the bill, will serve as a significant deterrent to fraudulent practices under medicare and medicaid.

Under current law, physicians or other individual practitioners who have been convicted of an offense related to their participation in medicare or medicaid are not automatically suspended from these programs and can continue to receive payment therefrom. The Secretary may suspend Federal payment to a person who has falsified information related to a request for payment. The Secretary may also suspend a person who bills the program for charges substantially in excess of the person's customary charges or who has furnished services found to be substantially in excess of an individual's need, to be harmful, or to be of grossly inferior quality.

The bill requires the Secretary to suspend from participation under medicare, a physician or individual practitioner who he determines has been convicted of a criminal offense related to such individual's involvement in medicare or medicaid. To permit case-by-case determinations, the suspension would be for such period as the Secretary deems appropriate and no medicare payment could be made for any item or service furnished by such individual during this period. Individuals subject to suspension are those who are convicted on or after the date of enactment of the law or within such period prior to enactment as the Secretary may specify in regulation. Provision is made for appropriate notice to the individual and the public and hearing and judicial review of the Secretary's determination. In any case where the Secretary suspends a practitioner from participation in medicare he is required to promptly notify every State medicaid agency and the appropriate State or local licensing authority.

Whenever a State medicaid agency is notified by the Secretary that a practitioner has been suspended under medicare, it shall suspend such individual from participation in medicaid. This is intended to prevent practitioners from moving from one State to another in order to avoid the effect of the suspension. To conform the timing of suspensions, the medicaid suspension period shall not be less than the suspension period applicable to the individual under medicare. No medicaid program payments may be made for services provided by such individual during the suspension period.

In his notification to the licensing authority the Secretary shall request that investigations be made and sanctions be invoked, as deemed appropriate in accordance with the State's law and policy. The Secretary and Inspector General would be notified of whatever action, if any, is taken by these authorities.

The committee was concerned that imposition of this suspension, under certain unusual circumstances, could deny adequate access to medical care to persons eligible for services under medicare or medicaid. To ensure that this would not occur, the bill provides two remedies. First, the bill would authorize the Secretary to designate a community as a health manpower shortage area (as defined under title III of the Public Health Service Act) for purposes of placement of National Health Service Corps personnel, if he determines that imposition of a suspension would leave those residents of the area eligible under medicare or medicaid without adequate access to health services. Second, the bill permits the Secretary, on the request of a

State, to waive a practitioner's suspension under the State's medicaid program. The committee intends that such waivers be granted sparingly. It is expected that waivers will only be approved where imposition of the suspension would deny a community of needed medical service because of the shortage of practitioners in that area and no National Health Service Corps personnel have been assigned.

Disclosure by Providers of Owners and Certain Other Individuals Convicted of Certain Offenses (Section 8)

The committee's bill requires all institutional providers of services participating in medicare, medicaid, or title XX State social service grant programs to disclose the names of owners and certain other individuals who have been previously convicted of fraud against any one of these programs.

Current disclosure of ownership provisions do not require institutional providers of services and other agencies and organizations certified to provide services under titles XVIII and XIX of the Social Security Act to disclose information about criminal records any of their owners and managerial employees may have. Similar information is also not required from institutional providers participating in title XX of the Social Security Act, a number of whom are also certified to provide services under medicare and medicaid. Existing procedures for determining this information are inadequate, time-consuming, and have permitted individuals previously convicted of such offenses to continue ownership or management in participating facilities or become owners or managers in other participating facilities without program administrators being aware of an individual's past activities which might have a bearing on a facility's future performance.

Lack of adequate disclosure of these individuals is an additional restraint on HEW's attempts to investigate and control program abuse. It has hampered and restricted Department efforts to limit the participation of those facilities and other organizations providing services under titles XVIII, XIX, or XX that are partially owned or controlled by persons convicted of criminal offenses against the programs.

Even when such individuals can be identified by the Department of HEW or State administering agencies, it is difficult under existing procedures to limit participation of facilities owned by these persons. Currently, no provisions exist to enable the Secretary of HEW or a State agency to refuse to enter into or to terminate provider agreements or contracts with institutional providers or other organizations owned by such individuals as long as existing conditions for participation under titles XVIII, XIX, or XX are met.

The result of the failure of the current law to provide procedures whereby facilities owned by persons who have previously been convicted of fraud aginst Medicare or Medicaid has been that these persons continue to receive payments from the programs. A recent report in the June 11 edition of the New York Times provides an example of this situation.

BERGMAN RESUMES NURSING HOME ROLE

FILING OF APPEAL VOIDS REVOCATION OF OPERATING LICENSE

(By Edith Evans Asbury)

> Bernard Bergman, who was convicted in Federal and state courts of Medicaid fraud in the operation of a string of nursing homes, is back in the nursing home business, operating the Park Crescent Nursing Home in Manhattan.
>
> Mr. Bergman's license to operate the Park Crescent was ordered revoked by state health authorities after he was convicted of Medicaid frauds involving more than $1.2 million and of tax frauds, including falsification of the books of the Park Crescent. He is appealing the revocation order.
>
> The nursing home, at Riverside Drive and 87th Street, has 500 patients for which Medicaid pays approximately $20,000 a day....
>
> * * * * * * *
>
> Dr. Robert P. Whalen, State Commissioner of Health, was also distressed.
>
> "It is terrible that he is back in the business," he said. "I am sure all of those involved in trying to improve the care of the elderly will feel terrible to learn of it."
>
> He added that he felt "helpless" at being unable to revoke the license "until the proper time expires" for Mr. Bergman to appeal, and was asking his legal staff "to continue to work with the Attorney General to see what other legal remedies might be available."
>
> "This points up the need," Dr. Whelan said, "for legislation we have ben seeking for two or three years which would prohibit felons from operating nursing homes, together with necessary procedural safeguards."

As this case illustrates, even criminal conviction is not sufficient to exclude an individual from the nursing home industry or the Medicaid system. Lengthy state administrative procedures must also be carried out, vulnerable to delaying litigation. The problem would be compounded under present law whenever a provider convicted in one state continues to operate in another. Then the speedy removal of the provider from the Medicaid program would be almost impossible. Conferring the proposed powers on the Secretary would ensure that providers who have flagrantly abused the system will not be able to exploit the delays in state administration processes to continue their profiteering.

In order to deal with this problem, as a condition of participation, certification, or recertification under titles XVII, XIX, or XX of the Social Security Act, the bill would require all institutional providers of services, or other agencies, institutions, or organizations to disclose to the Department of Health, Education, and Welfare or to the appropriate State agency the names of its owners, officers, directors, agents, or managing employees who have been convicted of a criminal offense against medicare, medicaid, or State social service grant programs. The bill specifies that when an application requesting such participation or certification contains the names of any such previously convicted individual, the Secretary of HEW or the State agency may refuse to enter into an agreement or contract with the institution to provide services under titles XVIII, XIX, or XX. In addition, the bill specifies that the HEW Inspector General must be informed of any such applications received and of any actions taken on them. The bill would also permit the Secretary or appropriate State agency to terminate existing provider agreements or contracts under titles XVIII, XIX, or XX, if the names of such individuals have not been disclosed, as required.

In applying the disclosure requirements to convicted persons who are officers, directors, agents, or managing employees of the institution, as well as to convicted persons with ownership interests, the committee feels that this parallel requirement is necessary in order to ensure that program administrators are aware of the renewed involvement of these persons in participating institutions.

The bill would specifically define the term "managerial employee" to mean a person who exercises operation or managerial control over the institution or one who directly or indirectly conducts the day-to-day operations of the institution including, but not limited to, an institution's general manager, business manager, administrator, and director. The bill would define the owner of an institution as any person who has a direct or indirect ownership or control interest of at least five percent in the institution.

Federal Access to Records (Section 9)

Under present law, State plans under medicaid are required to provide for agreements with every person or institution providing services whereby such persons or entities will keep complete records of services provided under the program and furnish the State agency, upon request, which information regarding any payments claimed under the program. Similar access to records by the Secretary is not required. The committee feels this could hamper Federal efforts to obtain information necessary to examine potential instances of fraudulent and abusive activities. The bill therefore specifically permits the Secretary to have access to records of persons or institutions providing services under medicaid in the same manner presently provided to State medicaid agencies.

Claims Processing and Information Retrieval Systems for Medicaid Programs (Section 10)

The bill permits States to send explanation of benefits forms to a sample of medicaid recipients and still be entitled to increased Federal matching for operation of approved management information systems. The bill specifies that there would be no explanation of benefit forms in the case of services which are confidential in nature.

Present law authorizes an increase in Federal matching to 75 percent toward the costs of operating an approved medicaid claims processing and information retrieval system if the system provides explanation of benefits information to all recipients. The committee has been informed that this strict requirement for explanation of benefit forms in every case has limited the growth of approved systems. In addition, questions have been raised about the cost effectiveness of this requirement because of the high volume of claims for services provided under medicaid.

The bill therefore modifies the current requirement by permitting the increased matching if the system provides explanation of benefits information to a sample group of recipients. The committee expects that the samples will be of sufficient size and sufficiently representative of the population served and the services rendered to enable the identification of any questionable or unusual patterns. It is the intention of the committee that all confidential services, and services integrally related to a confidential service, be deleted from the explanation of benefit forms in order to assure privacy for the medicaid patient. States will be expected to institute appropriate safeguards to accomplish this.

The committee notes that this change in the medicaid statute does not constitute a new entitlement to higher Federal matching, but merely increases the workability of the existing provision.

Medicaid As Payor of Last Resort (Section 11)

The bill precludes Federal matching payments for expenditures under medicaid for services which a private insurer would have an obligation to pay except for a provision of its insurance contract which has the effect of limiting or excluding such obligation because the individual is eligible for or receiving medicaid.

Under current law, States or local agencies administering medical assistance plans are required to take all reasonable measures to ensure that third parties legally liable to pay for any medical care rendered to medicaid recipients meet their legal obligations. However, some private insurance policies contain a provision that limits the insurance companies' liability to the amount not covered by medicaid. In some cases, State insurance commissioners have not taken action to stop this practice. When it occurs, the medicaid program is forced to assume the costs despite the existing subrogation requirement.

The bill would provide an incentive to States to stop this practice by stopping all Federal matching payments for expenditures made under the plan for care or services provided to the extent the private insurer (as defined by the Secretary) would have been obligated to pay except for a provision of its contract which has the effect of limiting or excluding such obligation because the individual is receiving assistance under medicaid.

Study and Review of Medicare Claims Processing (Section 12)

The bill directs the Comptroller General to conduct a comprehensive study of the claims processing system under medicare for the purpose of determining what modifications should be made to achieve more efficient claims administration.

Under medicare part A, groups or associations of providers can nominate an organization to serve as a fiscal intermediary between the providers and the government. An individual member of an association or group of providers that has nominated one organization as intermediary may select some other organization if this is satisfactory to the organization and HEW, or alternatively it may elect to deal directly with the government. HEW may not enter into an agreement with an organization unless it finds that such agreement is consistent with efficient and effective administration. The Social Security Administration has selected 10 hospital-nominated organizations to serve as intermediaries. This includes the Blue Cross Association which carries out its claims administration activities through 73 statewide and local Blue Cross Plans. Under medicare part B, the Secretary contracts with carriers to perform claims processing activities. Carriers are selected to serve specified geographic areas. There are 47 carriers, including 32 Blue Shield plans. Both intermediaries and carriers are reimbursed on a cost basis for carrying out their activities.

A reexamination of the administrative framework of the medicare program in order to assess the need for possible modifications is desirable.

The bill therefore directs the Comptroller General to conduct a comprehensive study and review of the administrative structure established for processing claims under medicare. The study is to determine whether and to what extent more efficient claims administration could be achieved by reducing the number of carriers and intermediaries, making a single organization responsible for processing claims under parts A and B in a particular geographic area, paying for claims processing on the basis of a prospective fixed price, providing other types of incentive payments for efficiency, or by other modifications in existing structure and procedures. The Comptroller General would be required to submit a report containing his findings and recommendations to the Congress by July 1, 1979.

Abolition of Program Review Teams Under Medicare (*Section 13*)

The bill repeals the provisions in current law relating to program review teams.

The Social Security Amendments of 1972 included a provision authorizing the Secretary to suspend or terminate medicare payments to a supplier of services found to have abused the program. In the case of such a suspension or termination, Federal participation was also to be withheld for medicaid payments made in behalf of such supplier. This provision was included to permit HEW to bar future payments to suppliers who have made a practice of furnishing inferior or harmful supplies or services, engaging in fraudulent activities, or consistently overcharging for their services.

To assist him in making determinations under this section, the Secretary was required to establish program review teams in each State. These professionally-based bodies were to advise the Secretary concerning such matters as whether excessive, harmful, or grossly inferior care is being rendered to patients. The functions of program review teams relating to the review of the quality and appropriateness of services are essentially duplicative of the functions required to be performed by PSRO's.

The bill therefore deletes the requirements in current law pertaining to the establishment and responsibilities of program review teams with the expectation that the appropriate PSRO will instead be available to advise the Secretary in cases that require the application of professional medical judgment.

termediaries, the assignment or reassignment of providers and the designation of regional or national intermediaries beginning on that date.

The bill further requires that agreements with intermediaires provide for access by the Secretary to all data, information and claims processing operations as he may find necessary to enable him to perform his required functions.

Disclosure by Providers of the Hiring of Certain Former Employees of Fiscal Intermediaries (Section 15)

The bill would require a provider of services under the medicare program to notify the Secretary promptly of its employment of an individual who at any time during the preceding year was employed in a managerial, accounting, auditing or similar capacity by a fiscal intermediary or carrier who had served that provider.

In certain cases in the past providers have specifically recruited and employed personnel of the fiscal intermediary serving it, apparently in order to assist the provider in justifying questionable accounting and cost reporting procedures. This type of hiring practice potentially subverts the integrity of the intermediary provider relationship, including the integrity of the auditing process. The Department of HEW is expected to utilize the information gained under the notification required under the bill to discourage such practices, especially when such information suggests possible conflict of interest situations.

Providers who hire employees of fiscal intermediaries, particularly accountants and auditors who have been involved in auditing that provider, should be on notice that such practices will be followed closely.

Payment for Durable Medical Equipment (Section 16)

The bill would modify the present methods for reimbursing medicare beneficiaries for expenses incurred in obtaining durable medical equipment. The intent of this modification is to reduce program expenditures and assure greater protection for beneficiaries against the need to pay excessive rental fees.

Present law provides for reimbursement under part B of medicare for expenses incurred in the rental or purchase of durable medical equipment used in the patients' home. The beneficiary has the option to rent or purchase such equipment. In the case of purchase, reimbursement is generally made in monthly installments equivalent to amounts that would have been paid had the equipment been rented.

Reimbursement may be made on a lump-sum basis for purchased equipment that is relatively inexpensive, i.e., items for which the reasonable charge is $50 or less.

Where a beneficiary elects to rent equipment, medicare will continue to reimburse him for 80 percent of his rental expenses as long as his medical need for the equipment continues. A study conducted by GAO showed that rental payments under the program for durable medical equipment require over an extended period of time frequently exceeded, by a substantial amount, the reasonable purchase price of the equipment. Moreover, beneficiaries were also overpaying for equipment since they are liable for the 20 percent coinsurance amount.

The Social Security Amendments of 1972 added provisions to the law to help avoid unreasonable expenses to the program and to beneficiaries resulting from prolonged rentals of equipment. These provisions authorized the Secretary to experiment with alternative reimbursement mechanisms, including the use of lease-purchase arrangements and lump-sum payments for purchased equipment where it could be determined in advance that the use of the equipment would be medically necessary for an extended period of time. Although the Department has not conducted the extensive experimentation contemplated by the legislation, sufficient evidence is available to indicate that changes in the reimbursement methods are needed to deal with the long-standing problems arising under the durable medical equipment provision of law.

To remedy these problems, the bill makes several changes in the methods used in reimbursing beneficiaries and suppliers for durable medical equipment. First, the bill requires the Secretary to determine, on the basis of medical evidence, whether the expected duration of medical need for the equipment warrants the presumption that purchase would be less costly or more practical than rental, and would not impose financial hardship on the beneficiary. Where such a presumption can be made, the Secretary would require purchase of the equipment and would provide reimbursement on the basis of a lump-sum payment or on the basis of a lease-purchase arrangement. Since lease-purchase would generally be the preferred mode of payment, and would ordinarily provide the greatest degree of cost-effectiveness for the program and the beneficiary alike, the bill specifically directs the Secretary to take steps to encourage suppliers, through whatever administrative arrangements he finds feasible and economical, to make equipment available to beneficiaries on a lease-purchase basis.

Secondly, the bill retains the provision in existing law which authorizes the Secretary to waive the 20 percent coinsurance requirement with respect to the purchase of used durable medical equipment whenever the purchase price is at least 25 percent less than the reasonable charge for comparable new equipment.

Funding of State Medicaid Fraud Control Units (Section 17)

The committee's bill authorizes 90 percent Federal matching payments for fiscal years 1978–1980, for the establishment and operation of State medicaid fraud control units.

The committee is concerned that sufficient efforts have not been made to date to identify and prosecute cases of medicaid fraud in a number of States. In the absence of effective investigative units, individuals engaging in fraudulent practices are able to continue their activities virtually unchecked. Sections of the bill provide for criminal sanctions and suspension actions for those convicted of medicaid fraud. However, strengthened penalties must be coupled with strengthened investigatory powers in order to assure that those engaging in criminal activities are identified and prosecuted. Further, the combination of rigorous enforcement and criminal sanctions should serve as a deterrent to similar practices by other providers and practitioners.

During the hearings held on this legislation, testimony was presented showing that where a separate investigative entity has been established, the rate of prosecutions and convictions has been substantially increased. For example, there was testimony that in the period from 1970 to January 1975, there was not a single prosecution in New York State for medicaid fraud arising out of the operation of a nursing home. In January 1975, a special office was established to examine the rapidly growing scandal in the nursing home industry. As a result of its investigations, grand juries have indicated more than 90 individuals mostly for medicaid fraud. To date, there have been 27 convictions and the office has forced payment of more than four million dollars in criminal restitution—an amount several hundred thousand dollars in excess of the office's first year budget. The committee was particularly impressed with the organization and operation of the New York Special Prosecutor's Office, and believes it constitutes a model for anti-fraud efforts in other States.

When the committee learned that a number of States are interested in establishing or strengthening existing medicaid fraud and abuse control units, it wished to encourage efforts similar to the New York unit. However, in view of the fiscal constraints being experienced by many of the States, the current 50 percent administrative matching rate has not served as a sufficient incentive to the establishment or expansion of such units. The committee believes that a short-term increase in the Federal matching rate of 90 percent will enable States to establish effective investigative entities and expand existing efforts. After these units have been operational for a few years, their recoveries from prosecutions should begin to equal or exceed the cost of operation. Therefore, under the bill, the increased matching rate would only be in effect for three years.

The bill, therefore, provides for 90 percent Federal matching for fiscal years 1978–1980 for the costs incurred in the establishment and operation (including the training of personnel) of State fraud control units meeting specified requirements, subject to a quartely limitation of the higher of $125,000 or one-quarter of one percent of total medicaid expenditures in such State in the previous quarter.

To be eligible for the increased matching rate, the State medicaid fraud control unit must be a single identifiable entity of State government which the Secretary certifies (and annually recertifies) as meeting specific requirements. Such entity must be a unit of the office of the State Attorney General or of another department of State government which has statewide prosecutorial authority (unless it is located in a State where the State constitution prohibits prosecution by a Statewide authority; then, to receive the higher matching, the unit must have procedures acceptable to the Secretary of HEW to refer suspected criminal violations to the appropriate prosecuting authorities, and to assist with the prosecutions).

The unit is required to be separate and distinct from the State medicaid agency. The entity must also conduct a statewide program for the investigation and prosecution of violations of all applicable State laws relating to fraud in connection with the provision of medical assistance and the activities of medicaid providers. Such unit is not however required to examine potential instances of recipient fraud; this function may continue to be the responsibility of the State medicaid agency. The fraud and abuse control unit must have procedures for reviewing complaints of the abuse and neglect of patients by health care facilities, and, where appropriate for acting on such complaints or for referring them to other State agencies for action. The entity is required to provide for the collection, or referral for collection, of overpayments made to health care facilities. In order to promote effective and efficient conduct of the entity's activities, it must be organized in a manner to achieve these objectives and it must employ auditors, attorneys, and investigators and other necessary personnel. The entity is further required to submit an application and annual report containing information deemed necessary by the Secretary to determine whether the entity meets these requirements. To facilitate implementation of this section, the Secretary is required to issue regulations within 90 days of enactment.

The committee wishes to emphasize the need for the employment of highly skilled auditors, attorneys, and investigators specially trained in the area of medicaid fraud. The committee has received substantial evidence of the complex schemes employed by those engaging in fraudulent activities and notes that the only way such practices can be effectively addressed by utilizing persons specially skilled in uncovering these activities.

The committee intends that the increased matching rate authorized under this section be made available to existing State fraud control units providing they meet (or appropriately modify their operation so as to meet) the specified requirements.

Report on Home Health and Other In-Home Services (Section 18)

The committee's bill would require the Secretary of Health, Education, and Welfare to report to Congress on home health and other in-home services authorized under title XVIII, XIX, and XX of the Social Security Act.

The committee is concerned that, with respect to home health and in-home services authorized to be provided under medicare, medicaid, and title XX social service programs, more effective methods need to be developed to assure the quality of services provided and efficiency in administration of the programs, and more effective efforts to curb fraud and abuse. While it is understood that there are, by necessity, differences among these programs in entitlement to the services and the types of services covered, it is the feeling of the committee that any efforts to develop methods of quality assurance and administrative efficiency should, where possible and practical, provide for coordination between the programs, particularly with respect to requirements for providers of services and reimbursement methods.

The Secretary is, therefore, directed to submit within one year a report to the appropriate committees in Congress analyzing all aspects of the delivery of home health and in-home services authorized under these titles. Further, since the intent of this legislation is to facilitiate establishment of a set of specific, enforceable standards in the programs to assure high quality home health services and the protection of the health and safety of recipients of such services, the Secretary is required to report on regulatory changes needed and to recommend appropriate statutory changes with respect to quality assurance and administrative efficiency.

The committee has not addressed the question of inclusion of proprietary home health agencies beyond the provisions of current law. However, the committee would note that the standards for quality review to be developed should be suitable for application to all home health providers, regardless of sponsorship.

The Secretary of Health, Education and Welfare has been designated to conduct this study in view of the extensive information gathered by the Department during recent regional hearings on home health care and the subsequent activity of the Department in analyzing this information. The Secretary is to include in this report an analysis of the impact of his recommendations on the demand for and cost of services authorized under the programs and the method of financing any recommended increase in the provision of such services.

Uniform Reporting Systems For Health Services Facilities and Organizations (Section 19)

The bill would require the Secretary to establish for each of the different types of health services facilities and organizations a uniform system for the reporting of such items as cost of operation, volume of services, rates, capital assets and bill data. This reporting system would be mandated for use by medicare and medicaid providers and such use would be phased in by type of provider.

A persistent problem under the medicare and medicaid programs as currently structured is the presence of variations in the information contained in medicare and medicaid cost reports. Since it is generally agreed that the existence of comparable cost and related data is essential for effective cost and policy analysis, the assessment of alternative reimbursement mechanisms and, in certain situations, the identification and control of fraud and abuse, the Committee believes it is necessary to correct the deficiencies in the present reporting system under these programs.

Accordingly, the bill requires the Secretary to establish for each type of health service facility or organization a uniform system for the reporting of the following types of informaton:

(1) The aggregate cost of operation and the aggregate volume of services;

(2) The costs and volume of services for various functional accounts and subaccounts;

(3) Rates, by category of patient and class of purchaser;

(4) Capital assets, as defined by the Secretary, including (as appropriate) capital funds, debt service, lease agreements used in lieu of capital funds, and the value of land, facilities, and equipment; and

(5) Discharge and bill data.

It is the committee's intent that the uniform reporting system for each type of health service facility or organization provide for appropriate variation in the application of the system to different classes of facilities or organizations within that type. The Secretary would be required to develop and establish uniform reporting systems, after consultation with interested parties, for hospitals, skilled nursing facilities and intermediate care facilities within a year following enactment of this legislation, and for other types of health service facilities and organizations (such as home health agencies) within two years of enactment.

Within each class of facility, cost allocation formats and definitions should be uniform. Each institution of a particular type performing a function to which a standard applies should be required to report on such functions in the same way. For example, all hospitals should be required to report X-ray costs on the basis of costs per patient exposure to diagnostic X-ray. Another type of institution, such as a long term care facility, may be required to employ another method, if one more suited to such type of institution's operations can be formulated. This combination of variation by institutional type and uniformity within each such type of institution provides necessary flexibility while assuring that the information obtained is useful.

It is also the committee's intent that the Secretary should take into account the unique organziational arrangement of health maintenance organizations, and should make those adjustments he finds necessary and appropriate to tailor the uniform reporting system to their particular situation, while maintaining the necessary comparability of data.

Under the bill. the Secretary would require all medicare and medicaid providers of services to submit reports to the Secretary of the aforementioned cost-related information in accordance with the uniform reporting system. For hospitals, skilled nursing facilities, and intermediate care facilities, these uniform reports would be required beginning with their first fiscal year that begins more than six months after the reporting system has been promulgated by the Secretary. For all other types of health service facilities or organizations, the reporting requirement will only be implemented at such time (after such systems are promulgated for these institutions) as the Secretary deems to be most productive. After establishing the uniform systems of reporting, the bill requires the Secretary to monitor their operation, assist with support demonstrations and evaluations of the effectivness and cost of the operation of such systems, encourage State adoption of such systems and periodically revise the systems to improve their effectiveness and diminish their cost.

Under the bill, the Secretary would be required to provide such information obtained through use of the uniform reporting system as may be necessary to assist health systems agencies and State health planning and development agencies carrying in out such agencies' functions.

Although this bill does not require uniform accounting as well as uniform reporting, the committee is convinced that the Secretary of HEW should develop model uniform accounting systems and that he should have the authority to require the use of such parts of the accounting system as he finds necessary in the future if his evaluation of uniform reporting indicates that it has not been sufficient to assure reliable and comparable data. The Committee notes that such authority is necessary to implement an effective and equitable hospital cost containment system, since payments based on comparative performances of like hosiptals requires a high degree of comparability of cost data.

Delay in, and Waiver of, Imposition of Reduction of Federal Medical Assistance Percentage Due to a State's Failure to Have an Effective Medicaid Utilization Control Program (Section 20)

Section 20 provides an additional 6-month period to States to meet the requirements of current Medicaid law concerning review of care delivered in institutional facilities. The section provides that if a State is in compliance for the calendar quarter ending December 31, 1977, the Secretary may waive all (or such part as is appropriate) of the reduction in the Federal financial assistance percentage which would otherwise be imposed on those States that failed to fulfill the requirements of law during the previous periods. The section further specifies procedural requirements for the Secretary to carry out the validation requirements under Section 1930(g)(2) in more timely fashion. The section defines the conditions a State must meet to be considered in full compliance with the utilization control requirement.

The "Social Security Amendments of 1972" (Public Law 92–603) added section 1903(g) to the Social Security Act. This section requires a one-third reduction in Federal matching payments under medicaid for long-term stays in institutional settings, unless a State demonstrates that it has an adequate program of control over the utilization of institutional services. The program must include a showing that:

(1) The physician certifies at the time of admission and recertifies every 60 days that the patient requires inpatient institutional services.

(2) The services are furnished under a plan established and periodically reviewed by a physician.

(3) The State has a continuous program of utilization review whereby the necessity for admission and continued stay of patients is reviewed by personnel not directly responsible for care of the patient, not financially interested in a similar institution, or, except in the case of a hospital, employed in the institution.

(4) The State has a program of independent medical review for SNF's, ICF's, and mental hospitals whereby the professional management of each case is subject to independent annual review. The section further requires the Secretary to conduct sample onsite surveys of institutions as part of his validation procedures.

The committee notes that this section was to go into effect on July 1, 1973, as an incentive payment for States showing a satisfactory program of utilization control. States which did not make the requisite showings were automatically to be subject to the reduced Federal matching rate. Despite the clear intent of the law and extensive evidence developed by the Subcommittee on Oversight and Investigations as well as the Comptroller General of the United States, that a large number of States failed to meet the requirements, HEW indicated that it was reluctant to impose the reductions. The first reduction actually to be imposed under this authority was announced to take effect July 1977. During the intervening four-year period the committee has on a number of occasions, both during hearings and in a report prepared by the committee, indicated its concern that HEW had failed to fulfill its responsibilities.

On June 8, 1977, HEW announced that it would reduce July 1977 Medicaid payments to 20 States by a total of $142 million (actual application of these announced reductions was delayed by Public Law 95–59 until October 1977). These reductions were to take effect because the States failed, during the first quarter of 1977, to conduct annual medical reviews of patients in long-term care facilities. The Department further announced that it had under review the potential disallowance of $378 million of fiscal year 1975 funds for failure to have adequate utilization controls in place, based upon validation requirements. The committee is encouraged that the Department has begun to aggressively implement the congressional mandate. However, in view of past inaction on the part of HEW, it feels that the sudden reduction in Federal funds for past years activities could have a severe and unanticipated impact on affected State Medicaid programs. Further, Congress intended this program to be an incentives program to be validated on a current basis by HEW. Section 20 is intended to bring this validation process into timely synchronization with State showings.

The committee has approved an amendment which would give States an additional 6 months to demonstrate full compliance with the law. The committee emphasizes that this is in no way to be viewed as a retrenchment or a lack of resolve on its commitment to effective utilization control and medical audit programs. It fully expects and intends that during this extension period all States will take the necessary actions to bring them into full compliance.

The committee bill amends section 1903(g) to provide that no reduction shall be imposed before January 1, 1978, unless a notice of the decrease is provided to the State at least 30 days in advance and unless notice of the reduction occurs no later than nine months following the period for which the State has been cited for noncompliance.

The Secretary is required to waive application of all or part (as is appropriate) of any decrease otherwise required to be imposed with respect to cases of noncompliance occurring prior to October 1, 1977, if he determines that the State makes a satisfactory showing, and the showing is valid, that it is in full compliance with the law for the last quarter of calendar year 1977. The committee has left to the Secretary's discretion the amount of the decrease which may be waived. It fully expects that where previous violations of the law have been of sufficient magnitude, the Secretary may impose a portion of the penalty. In cases where the State is not able to show a satisfactory program that is validated by the Secretary, the committee expects that all previous reductions will be taken.

The committee bill provides that a State should provide its showing with respect to a calendar quarter to HEW within 30 days of the end of the quarter, so that HEW can make the appropriate determinations and give States sufficient notice of any action (although HEW can extend the period if the Secretary finds good cause for doing so). The section further clarifies the conditions a State must meet to be deemed in full compliance with the on-site medical and independent review requirements. It must demonstrate good faith efforts to conduct on-site surveys in all mental hospitals, SNF's and ICF's and actually conduct such surveys in all large institutions, and in all other institutions in the State. This provision was included because HEW has announced penalties on States which failed to review only two or three homes out of hundreds of homes subject to review within the annual time limit. In the light of the Secretary's position that HEW has no discretion in determining that the requirements of the law have been met, the Committee has provided a standard of reasonableness in the bill.

While existing law requires the Secretary to undertake on-site validation surveys in timely fashion, HEW has not done so in the past. When they have performed validations, the validations have lagged months and even years behind the year in question. The committee believes HEW has an obligation to the States, to the Congress, and to institutional care recipients to undertake validations in a timely fashion, and to impose any reductions resulting from them at that point. States should not be subjected to the uncertainty of a possible reduction years later. Therefore, the committee reluctantly concludes that HEW should not attempt validations of periods now long past, but should begin now appropriate validations of calendar year 1977, so that they can complete their validations shortly after the December 31, 1977, date for State compliance. The bill requires that the Secretary must complete his validations and give notice of his determinations within nine months of the end of the period in question if he is imposing reductions on the States as a result.

The section also requires the Secretary to submit to the Congress within 60 days of the close of each calendar quarter a report on: (1) his determination as to whether showings made by States are satisfactory; (2) his review of the validity of previously submitted showings; and (3) any reductions made for the quarter.

VI. Congressional Budget Office Cost Estimate

A cost estimate was requested on H.R. 3 when it was ordered reported from the committee on Interstate and Foreign Commerce, and the Congressional Budget Office has provided the following information.

Congressional Budget Office,
Washington, D.C., June 28, 1977.

Hon. Harley O. Staggers,
Chairman, Committee on Interstate and Foreign Commerce, U.S. House of Representatives, Washington, D.C.

Dear Mr. Chairman: Pursuant to section 403 of the Congressional Budget Act of 1974, the Congressional Budget Office has reviewed H.R. 3, the Medicare-Medicaid Fraud and Abuse Amendments, with regard to its potential cost impact.

The provisions in H.R. 3 are intended to clarify and extend current statute in order to facilitate both state and federal efforts to monitor and control possible fraud and abuse in the Medicare and Medicaid programs. This is accomplished in the bill through the expansion both of legislative powers and sanctions and of the collection and coordination of relevant information, as well as through the provision of increased funding to the states to support such activities. Lastly, as a means of further reducing costs, the bill permits the Secretary of HEW to require that necessary durable medical equipment be purchased rather than rented under medicare if it is determined that purchase would be a less costly alternative.

Thus, many of the provisions in this bill represent possible added costs or savings (or both) to the programs. Some sections, for example, although requiring additional expenditures, are intended to actually reduce costs, thus representing no net outlay effect. However, limitations of available and relevant data, uncertainties of the actual extent and effectiveness of the future implementation of the provisions, and the unknown magnitude of the fraud and abuse presently extant in the programs make it impracticable for CBO to project the actual cost impact of this measure at this time.

Our review of the bill and the limited information available leads us to conclude that costs and savings would essentially offset each other during the first couple of years of implementation with some

The new section 1171(e)(1) requires the Secretary to establish in a timely manner procedures and mechanisms to govern his relationships with State agencies under part B of title XI (specifically including his relationships with such agencies in connection with their respective functions under the preceding provisions of this section). Such mechanisms shall include periodic consultation by the Secretary with representatives of the State agency and of PSRO's regarding relationships between them (including the appropriate exchange of data and information between such agencies and such organizations) and other problems of mutual concern. Such procedures shall permit the State agency to be represented on any project assessments conducted by the Secretary with respect to a PSRO located within its State.

The new section 1171(e)(2) requires each PSRO to provide the appropriate State agency on request (a) data or information which the Secretary requires such organizations to report to him routinely on a periodic basis, and (b) such other data or information as the Secretary authorizes to be disclosed.

Section 5(d)(3)(A) of the bill amends section 1155(e)(1) of the Social Security Act by prohibiting delegated review in skilled nursing facilities.

Section 5(d)(3)(B) of the bill amends section 1155(a) by providing that required review specified in paragraph (1) is subject to the exceptions provided in the new paragraph (7).

The new paragraph (7) specifies that a PSRO has the function and duty to assume responsibility for the review of professional activities in intermediate care facilities (as defined in section 1905(c)) and in public institutions for the mentally retarded (described in section 1905(d)(1)), only if the Secretary finds, on the basis of such documentation as he may require from the State, that the appropriate State medicaid agency is not performing effective review of the quality and necessity of health care services provided in such facilities and institutions.

Section 5(e) amends section 1160(b)(1) of the Social Security Act to clarify that the sanctions provision applies to any health care practitioner or hospital, or other health care facility, agency, or organization subject to PSRO review.

Section 5(f) amends section 1163(a)(2) of the Social Security Act by substituting a new provision.

The new section 1163(a)(2) provides that members of the National PSR Council shall be appointed for a term of three years, except that of the members appointed in 1979, four shall be appointed for a term of only two years, and three for a term of only one year. Members of the Council shall be eligible for reappointment.

Section 5(g) deletes section 1163(f) of the Social Security Act pertaining to the requirement for an annual report prepared by the National Council.

Section 5(h) amends section 1166 of the Social Security Act by redesignating subsection (b) as subsection (d), adding new subsections (b), (c), and (e), and making appropriate changes in cross references.

SEPARATE VIEWS OF REPRESENTATIVE DAVID E. SATTERFIELD, III

The necessity for confidentiality in the relationship between doctor and patient has been appreciated for as long as medicine has been practiced. The duty of the physician to preserve the confidentiality of information obtained from his patients is explicitly recognized in the Hippocratic Oath and the American Medical Association's Principles of Ethics.

Fortunately, as a result of this recognition, the confidentiality of medical records has rarely been abused, and most patients assume that their privacy will be protected by the medical profession. Nevertheless, concern has been increasing that the ethics of the medical profession are no longer sufficient guaranty of the confidentiality of medical records. I see two basic reasons for this increased concern. First, the Health Care System of the United States is changing rapidly. The role of the Federal Government in paying for, providing and reviewing health care has increased enormously and all signs are that it will continue to increase. A growing percentage of health care is being provided by institutions—hospitals, HMO's, clinics—rather than by physicians practicing alone, and that care is more and more likely to be paid for by a third party. Consequently, when the individual patient provides sensitive information to a physician he may be placing that information within the control of an enormous, interlocking, health care bureaucracy. Secondly, the application of computer technology in the field of health care is steadily increasing. This development is described by Professor Alan F. Westin in a study prepared for the U.S. Department of Commerce [1]:

> Spokesmen from medicine and the computer industry expect the use of computers in doctor's offices and small clinics to move slowly but steadily upward in the next five years. They cite the increased exposure to computers that physicians receive as they treat their patients in hospitals; courses in medical schools about administrative and clinical uses of computers; the current trend toward greater group rather than solo practice, creating more practice units for which computers could be cost-effective; and the funding of various projects (such as CAPO) by federal health agencies to develop tested applications and encourage greater EDP use in doctors offices. Possibly the most important factor is the rapid price decline that is taking place in computing services, as small-system computers and minicomputers move into monthly costs for business data processing that many physicians are finding attractive." (at page 95)

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[1] Westin, Alan F., Computers, Health Records, and Citizens Rights, Nat. Bur. Stand. (U.S., Monograph 157 (Dec. 1976)).

> As in doctor's offices, computer use in hospitals is changing the nature of the patient's file. In many hospitals in the pre-computer era, record-keeping was hit-or-miss, and though lots of paper accumulated in the record, these documents were often in disarray, without any indexing or current summary. Now, while the character of personal information that is being collected for automatic patient records is not different from what was recorded before, the automated personal data are being more systematically collected, more fully recorded and more centralized in permanent files. Patients processed through automatic history-taking are systematically asked to disclose the full range of physical, social, family, emotional and other personal data, and the resulting detailed patient profiles become a regular feature of the file, updated steadily as the patient remains with that care provider.
>
> From a health care standpoint, this is one of the most desirable features of automation—patient records are full, up-to-date, easily understood and are linked together from various departments and previous episodes. From a civil liberties standpoint, however, this trend means that all the medical and paramedical personnel in a facility who have access to the computerized files now have more detailed personal data and more comprehensive social histories than in the typical manual system, except for psychiatric facilities.
>
> In addition, computerization of patient data is facilitating (and is sometimes directly intended to facilitate) the sending of some automated patient data to organizations outside the primary care sector—to service payers and those charged with quality care assurance, and to the Zone 3 users such as public health agencies, welfare and rehabilitation programs, licensing authorities, judicial authorities, employment-insurance evaluators and so forth." (at pages 99–100)

In response to concern over these developments, the House Ways and Means Committee adopted an amendment to H.R. 3 which would limit the access of federal officers, employees, and agents to individually identifiable medical records without the consent of the patient. Unfortunately, this amendment would be overly broad and indiscriminate in its effects. It fails to make exceptions for those situations in which the health of the general public must override the right to privacy of the individual. For example, as Professor Westin points out:

> While securing informed, voluntary consent should cover most situations in which medical research and program evaluations need to be conducted, through the use of identified data from health systems, there will be situations in which this is not feasible.

I share the belief that statutory protection for the privacy of medical records is needed, especially with respect to access by federal employees to the records of individual patients whose medical care is not financed in whole or in part by the Federal Government. To legislate merely to limit the disclosure of medical information about a citizen obtained by federal employees without the knowledge or consent of that patient is grossly inadequate. This belief has been strengthened by the recently released Department of HEW audit agency report, which revealed a shocking lack of security for computerized records of the Social Security Administration containing highly confidential personal information on millions of Americans. Particularly disturbing was the revelation that many federal employees have access to this personal information even though their jobs do not require such access.

I can think of no right more deserving of protection than the right to confidentiality of one's medical file. I do recognize, however, that there are occasions and circumstances when the public interest transcends the individual right, for example in cases of communicable disease. Even so, the accessability of a citizen's medical record in such circumstances should be clearly and carefully circumscribed. I can think of no better way to insure this protection of the public interest than to permit federal health officials to aid and assist the chief medical officer of the individual states when specifically requested to do so, and then only to the extent permitted by state law governing the authority of the chief medical authority in such state.

Accordingly, I shall offer an amendment which, except in the case of a medical emergency presenting an immediate threat to the life of an individual patient, would require federal officials, employees, or agents, before inspecting or requiring the disclosure of individually identifiable medical records, to obtain the written consent of the patient. It would further permit such inspection and disclosure when the federal health official or officials are requested to do so in writing, by an official authorized by state law to inspect or require the disclosure of medical records, with the further provision that the purpose and scope of authority to be exercised as well as the period of time such authority is delegated be also set forth in writing.

This basic safeguard would impose only a reasonable, minimal inconvenience on researchers and other federal health officials, an imposition which in my view is more than warranted by the added protection for individual privacy which it affords.

The amendment would not apply to alter the present rules governing access to medical records in the possession of the Armed Services or the Veterans' Administration. Nor would it apply to inspection of medical records in the course of (1) the delivery of medical care which is paid for or provided by the Federal Government, (2) review by PSROs of medical care paid for or provided by the Federal Government, and (3) auditing for, investigating, or prosecuting fraud and abuse in the provision of, or payment for, medical care which the Federal Government provides.

In drafting this amendment, I have taken great pains to insure that Federal assistance to State and local authorities in the control of communicable disease, the investigation of epidemics, and in epidemiologic research would not be unduly hampered.

It has been suggested that Congress should postpone action in this area until the final report of the Privacy Commission is received and the Department of HEW has had an opportunity to study the report and submit suggestions for legislation. This, of course, would virtually insure that no legislation governing the right of privacy in question will be enacted during this session of Congress. I do not feel such a delay is justified. A provision such as I propose is a careful first step and is fully consistent with the Draft Medical Records Policy Recommendations of the Privacy Commission. Adoption of it would in no way preclude future legislation on this point. Again, Professor Westin's observations are pertinent:

> Predictably, there are divergent views among observers as to the nature and extensiveness of threats to privacy in various new helath care programs, in in the growth of automated data systems. But there is widespread agreement that dealing wisely and effectively with the privacy 'issue' is a vital matter, not only to the public's confidence in new health care institutions in the coming decade but also to the protection of fundamental citizen rights.
>
> The time is ripe, therefore, for focusing expert and public attention on these issues before changes in health care financing and review are enacted, before the new wave of computer applications and information systems unfold, and before arrangements to incorporate national patient identifiers and file-linking arrangements in the health field are put into place." (at page 2)

For the foregoing reasons, I urge my colleagues to support my amendment on the floor of the House when H.R. 3 is considered.

David E. Satterfield. III.

ADDITIONAL VIEWS BY MR. ROGERS

During the course of the Subcommittee consideration of H.R. 3, a significant amount of time and attention was devoted to the issue of the confidentiality of individually identifiable medical records. Much of the discussion centered around two alternative approaches:

(1) The approach adopted by the Ways and Means Committee, which bans all access to and inspection or disclosure of individually identifiable medical records by Federal employees, officers, agents, and PSRO's without specific, detailed, time-limited consent of the individual concerned, whether the care is paid for by public or private sources, with the following exceptions: (a) a PSRO may have access to the medical records of persons whose care was paid for by Medicare, Medicaid, or the maternal and child health program for the purpose of performing utilization review, or (b) the care is paid for by medicare, medicaid or the maternal and child health program, and inspection of the record is for purposes of auditing for, investigating or prosecuting fraud and abuse.

(2) The approach adopted by the Committee on Interstate and Foreign Commerce (a) which banned access or disclosure to Federal employees of individually identifiable medical records in the possession of the PSRO where the care was not paid for by Medicare, Medicaid or the maternal and child health program, without the specific consent of the patient, and (b) which required the Secretary of HEW to submit proposed legislation within three months of the issuance of the Privacy Protection Study Commission report, which embodies the recommendations of that group pertaining to the privacy of patients' medical records, the circumstances under which they may be examined, and the safeguards which should be established with respect to examination and disclosure.

The subcommitte received little evidence of abuse by Federal employees of their access to individually identifiable records. They did receive assurance that unwarranted disclosure is subject under current law to up to 1 year imprisonment and a fine of up to $1,000, or both, and loss of employment. While we felt a great deal of concern that the privacy of patient records should be protected, the subcommittee members also believed that certain vital activities to protect the health and safety of the population should not be unnecessarily impaired. Further, we were convinced by statements of members and staff of the Privacy Commission that translating the Commission's recommendations into law would require careful and time-consuming deliberations and painstaking attention to detail since the nuances of language are extremely important and can have far-reaching implications in this area. After weighing all aspects of the issue, the subcommittee determined that it was the prudent and appropriate course to wait until the Privacy Commission's final report was issued, to allow the administration to formulate suggested legislation, to hold public hearings on the legislation and other legislative approaches that might be suggested by Members, and then report a bill to the House which we can recommend with assurance.

During the full committee consideration of H.R. 3, my colleague, the Honorable David Satterfield, proposed an amendment concerning confidentiality of medical records which, while patterned on the approach followed by the Ways and Means Committee, provided additional exceptions to the ban on Federal access to records without specific individual consent. These exceptions included (a) the inspection or disclosure is made on the specific request of an official authorized under State law to inspect or require the disclosure of records, and whose request states the specific purpose of the disclosure, who may inspect the record, over what time period, etc.; (b) the inspection or disclosure is made to meet a medical emergency presenting an immediate threat to human life; (c) the care is paid for in whole or part by the Federal government and access to the record is for the purpose of providing care, is by a PSRO or others to carry out utilization review, or is to investigate fraud or abuse, or (d) the access is authorized by legislation relating to the armed forces or veterans benefits. While the amendment proposed by Congressman Satterfield removes some of the objections to the more stringent amendment adopted by the Ways and Means Committee, it by no means addresses sufficiently the problems heard in testimony before the subcommittee.

First, although the proposed amendment sets up an exception for instances of medical emergency, access to medical records is often needed to determine whether or not there is in fact an emergency. The records themselves disclose the facts upon which action by the Center for Disease Control, for example, is predicated. Such access would be precluded by this amendment. Because of this, the restrictions contained in the amendment would undermine the investigations of epidemics, the search for causes and prevention of disease, and the monitoring of the quality of research on new drugs.

Investigation of an epidemic might appear to be manageable with the Satterfield provision for access upon the request of a State official. But this is not the case. The Center for Disease Control in fact does not now investigate epidemics or perform hospital or medical record review without the State's request or agreement. But if State legislative authority of the specificity required in this amendment becomes the basis for future cooperation, immediate and complicated legal problems will certainly surface. There are substantial variations in legislative authority, state by state, for such requests for assistance. HEW has estimated that in one quarter of the States, the authorities—particularly relating to chronic, occupational, and environmentally related disease—are vague or nonexistent. Doubts and confusion about the authority of State officials to authorize Federal access under this amendment would complicate the currently smooth, productive, effective Federal-state cooperation in disease control. Prompt investigation of epidemics would almost certainly be impeded.

Research into the origins and course of disease would be also halted. Access to records for long-range research purpose is not appropriate keyed to the authority of State officials, whose authority to inspect or require disclosure of records is typically not explicit. Neither does "medical emergency" exception offer much basis for investigating the course of an illness like cancer in a large population over a period of time.

It is a cruel distinction to permit disclosure when the danger is immediate, but to deny to future generations the possibility of elucidating the origins of the disease and developing measures for prevention or cure.

In assuring the quality of research used in support of new drug applications, it is sometimes necessary to inspect the records of patients to whom the drugs were administered. This is essential to establishing that drugs are safe for public use. Requiring prior consent would prevent this, because it is impossible to know the identity of the patient before examining the record.

The work of the National Institute for Occupational Safety and Health (NIOSH) could also be adversely affected. The Institute's research has been vital to establishing standards protecting many thousands of American workers from such cancer-causing agents as asbestos, vinyl chloride, coke oven emissions, and 14 chemical carcinogens.

Many occupational diseases, particularly occupationally-induced cancer, take many years to develop. To establish cause and effect relationships between exposure and disease, NIOSH may need access to all plant medical records for certain employees going back as many as 20 or 30 years. Frequently those employees are no longer at the plant and may not be readily available to give permission for examination of their records.

There could also be a problem if the workers were still employed at the plant. If individual consent were required for examination of those records, an employer would be in a position to discourage his employees from permitting access to employment-related medical records, thus preventing a thorough assessment of the health risks at the plant.

An additional concern is that the proposed amendment sets up a double standard, one for Veterans, employees of the Defense Department and those whose care is financed by the United States, and another for the balance of the residents of this country. David F. Linowes, Chairman of the Privacy Commission, has stated that this differs from the Commission approach which seeks to establish uniform standards for all medical record information. Differentiation of the rights to privacy on the basis of who pays for the care is not a precedent which should be accepted lightly. If such a differentiation is to be made, surely it should be limited to inspection of records, not disclosure of them.

This is only an initial set of concerns with the aproach suggested by my colleague. I have no doubt that further study of the amendment and its review by persons engaged in public health, cancer research, and similar activities would uncover more problems. It seems apparent that legislation in this complex area should build on the Privacy Commission Study and should not be adopted in haste. It should be carefully reviewed in a full set of legislative hearings with the benefit of the advice and consultation of the public. That, in my view, is the only responsible course for the Congress to follow.

PAUL G. ROGERS.

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Calendar No. 416

95TH CONGRESS } SENATE { REPORT
1st Session } { No. 95-453

MEDICARE-MEDICAID ANTI-FRAUD AND ABUSE AMENDMENTS OF 1977

REPORT

OF THE

COMMITTEE ON FINANCE
U.S. SENATE

ON

S. 143

RECEIVED
OCT 7 1977
DIV. OF [illegible] AND
MEDICAL [illegible] POLICY

SEPTEMBER 26 (legislative day, SEPTEMBER 22), 1977.—Ordered to be printed

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Calendar No. 416

95th Congress } SENATE { Report
1st Session } { No. 95-453

MEDICARE-MEDICAID ANTI-FRAUD AND ABUSE AMENDMENTS OF 1977

September 26 (legislative day, September 22), 1977.—Ordered to be printed

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Mr. Long, from the Committee on Finance,
submitted the following

REPORT

[To accompany S. 143]

The Committee on Finance, to which was referred the bill (S. 143) to strengthen the capability of the Government to detect, prosecute, and punish fraudulent activities under the medicare and medicaid programs, and for other purposes, having considered the same, reports favorably thereon with amendment and recommends that the bill as amended do pass.

I. Summary of the Bill

As reported, the provisions of S. 143, the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977, are focused on six major areas: Strengthened program penalty sanctions, increased disclosure of information, needed improvements in the professional standards review program, administrative reform, and other medicaid and medicare amendments. The summary presented below briefly outlines the principal features of the bill as reported.

Program Penalty Sanctions

1. The bill modifies the penalty provisions in existing law which relate to those persons providing services under medicare and medicaid. Most fraudulent acts now classified as misdemeanors are to become felonies. Penalties are to be increased to a maximum $25,000 fine, up to five years imprisonment, or both. The types of financial arrangements and conduct to be classified as illegal have been clarified. In addition, States will now be permitted to suspend the eligibility of medicaid recipients convicted of defrauding the program. However,

the misdemeanor penalty presently provided under existing law for conviction of such individuals is retained, as is the misdemeanor penalty for the conviction of a beneficiary under the medicare program. The bill also requires the Health, Education, and Welfare Inspector General to include in his annual report an evaluation of the effort of the Department of Justice in the investigation and prosecution of fraud in the medicare and medicaid programs and his recommendations for improvement of that effort. (Section 4)

2. The bill requires the Secretary of Health, Education, and Welfare to suspend, for such period as he deems appropriate, from participation under medicare and medicaid, an individual practitioner who has been convicted of a criminal offense related to such individual's involvement in medicare or medicaid. When the Secretary suspends an individual, he must also notify the appropriate State licensing authorities, requesting that investigation be made and sanctions invoked in accordance with the State's law and public policy. (Section 7)

Disclosure of Information

1. (a) The bill requires, as a condition of participation or certification in either medicare, medicaid or the maternal and child health program, or health-related entities providing services under title XX, the annual disclosure to the Secretary or the appropriate State agency by the participating entity of the identity of any person who has a five percent or more ownership interest in the entity. These disclosure of ownership provisions will apply to medicare and medicaid providers of services (including independent clinical laboratories, health maintenance organizations and renal disease facilities), entities furnishing services for which payment may be claimed under medicaid or the maternal and child health program (but not including any individual or group of practitioners), and medicare carriers or intermediaries and medicaid fiscal agents. Providers of services would also have to disclose similar ownership information about any subcontractor, five percent or more of which is owned by the provider. (Section 3)

(b) Furthermore, the bill modifies existing medicare and medicaid provisions relating to termination of medicare provider agreements or suspension of medicaid payments to health care entities by adding a requirement that a provider must comply with a request specifically addressed to it by the Secretary or the medicaid State agency for full and complete information as to any significant business transactions between it and any subcontractors or between it and wholly-owned suppliers. Finally, in the case of subcontractors having more than $25,000 in annual business transactions with a provider, compliance would be required with similar requests related to ownership information pertaining to the subcontractor. (Section 3)

2. The bill requires all institutional providers of services, or other agencies, institutions, or organizations, as a condition of participation or certification in medicare, medicaid or the social services programs under Title XX of the Social Security Act to disclose, in the application for participation or certification, the names of owners, officers, directors, agents, or managing employees who have been convicted of fraud against the medicare, medicaid, or State social service grant programs. Where an application contains the name of any such pre-

viously convicted individual, the Secretary or the State agency can refuse to enter into an agreement or refuse to contract with the applicant. The Inspector General of the Department of Health, Education, and Welfare must be informed of the receipt of any such applications and of any action taken on them. (Section 8)

3. The bill authorizes the Comptroller General of the United States to sign and issue subpenas in order to obtain necessary information and facilitate review of Social Security Act health programs. The Comptroller General will also be authorized, upon resistance or refusal by an individual to obey a subpena, to request a court order requiring compliance with the subpena. (Section 6)

4. The bill requires any provider of services participating in medicare to promptly notify the Secretary of its employment of an individual who, at any time during the preceding year, was employed in a managerial, accounting, auditing, or similar capacity by a medicare fiscal intermediary or carrier that services the provider. (Section 15)

5. The bill allows Federal access to the records of persons or institutions providing services under medicaid in the same manner that such access is presently provided to State agencies. (Section 9)

6. The bill authorizes prosecution of civil fraud cases under the Social Security Act health care programs by the Inspector-General of HEW where U.S. attorneys have not initiated proceedings within six months of formal referral of a case. (Section 23)

Professional Standards Review

The bill includes several provisions designed to clarify the nature and scope of PSRO review responsibilities, to enhance the capacity of PSRO's to perform reviews of the necessity and appropriateness of services more effectively, and to improve the administration and coordination of review activities so as to assure that program funds are properly expended. Thus, the bill provides:

(1) for the termination of other duplicative review activities when the Secretary determines that a PSRO is competent to perform its review responsibilities; that the determinations of PSRO's so recognized by the Secretary with respect to the necessity and appropriateness of care are conclusive for purposes of program payment; and that the role of the State in the process of establishing and evaluating PSRO review of services provided through the medicaid program will be increased and made more specific (Section 5(a) and 5(d));

(2) for the establishment of demonstration projects for the purpose of evaluating the effectiveness of PSRO reviews compared to alternative State review methods. The bill authorizes the establishment of such projects in States which had operating onsite State evaluation systems in place on August 5, 1977, and which make application to the Secretary prior to April 1, 1978. The purpose of the projects will be to evaluate the effectiveness both in terms of the quality and appropriateness of medical care as well as the impact on State budgets, of PSRO hospital review compared to alternative State hospital review systems. Demonstration projects would be conducted in PSRO areas which are

representative of a State's medicaid population and comprise a significant proportion of medicaid patient days (Section 24);

(3) that a PSRO may be conditionally designated for a period not to exceed 48 months (with authority for the Secretary to extend the period for an additional 24 months where warranted by unusual circumstances); and that PSRO's must assume review responsibilities for institutional services during this period (Section 5(b));

(4) that the Secretary shall require a PSRO, where he finds it is capable of undertaking ambulatory care review, to undertake such review no later than 2 years after it becomes fully operational (but not during such organization's conditional phase), and to give priority to requests by PSRO's to review services in "shared health facilities" (Section 5(c));

(5) that the Federal Government may assume the defense costs incurred by a PSRO in a liability suit related to the performance of its functions (Section 5(i));

(6) for the disclosure of information with respect to evidence of fraud to designated Federal and State law enforcement agencies (with a prohibition against access to PSRO records in the case of subpena or discovery proceedings in a civil action), and for the disclosure of aggregate statistical data to Federal and State health planning agencies (Section 5(h));

(7) for the annual submission to the Congress by the Secretary of a comprehensive report on the administration, cost, and impact of the PSRO program (Section 5(k));

(8) for the modification of current law provisions pertaining to payment for institutional services after a PSRO has determined that such services are no longer required. The current three day grace period would be reduced to one, with the PSRO permitted to authorize up to 2 additional days on a case-by-case exception basis where the facts in the case indicate that the additional time is needed to arrange for the necessary postdischarge care (Section 22);

(9) to amend the Internal Revenue Code to specifically include PSRO's as organizations eligible for section 501(c)(3) tax status (Section 27); and

(10) for several clarifying administrative and technical changes designed to enhance a PSRO's operational capacity (Section 5).

Administrative Reform

1. The bill requires the Secretary to establish for each of the different types of health services institutions a uniform system for the reporting of such items as cost of operation, volume of services, rates, capital assets and bill data. This reporting system would be mandated for use by medicare and medicaid providers and such use would be phased in by type of provider. (Section 19)

2. The bill repeals the program review team provisions of present law. The functions formerly performed by such teams with respect to the quality and utilization of services will be performed by Professional Standards Review Organizations. (Section 13)

3. The bill would encourage each State to establish an office separate from the medicaid program agency to prepare and prosecute cases of

suspected fraud and abuse in the program by providing for 100 percent Federal matching funds in fiscal year 1978, 90 percent in fiscal year 1979 and 75 percent in fiscal year 1980 for expenditures to establish and operate State medicaid fraud control units. The bill also authorizes the Secretary to arrange for demonstration projects designed to develop improved programs for detection, investigation, and prosecution of fraud and abuse. (Section 17)

4. The bill requires States to make provision in their State medicaid plan for claims payment procedures which ensure that 95 percent of the bills submitted by eligible noninstitutionally-based providers will be reimbursed within 30 days, and 99 percent within 90 days. The State would not be cited for noncompliance if the Secretary found the State was acting in good faith to achieve this goal. (Section 2)

5. The bill directs the Comptroller General to conduct a comprehensive review of the administrative structure for the processing of medicare claims. (Section 12)

6. The bill would prohibit the Secretary from refusing to enter into an agreement with a nominated intermediary under medicare solely because of the fact that such intermediary does not operate regionally or nationally. (Section 14)

7. The bill establishes a medical support program under which medicaid applicants and recipients may be required by a State to assign their rights to medical support or indemnification to the State. Incentives would be provided for localities to make collections for States and for States to secure collections in behalf of other States. (Section 11)

8. The bill requires that as a condition for participation in the medicaid and medicare programs, a skilled nursing or intermediate care facility must establish and maintain a system to assure the proper accounting of personal patient funds. The system must provide for separate and discrete accounting for each patient with a complete accounting of income and expenditures so as to preclude the intermingling of other funds with patient funds. (Section 21)

Other Medicaid and Medicare Amendments

1. The bill modifies the requirements of current medicaid law concerning review of care delivered in institutional facilities. The section waives application of the penalties for noncompliance for calendar quarters ending prior to January 1, 1978. For subsequent calendar quarters, the required reductions in Federal matching would be imposed only in proportion to the number of patients whose care was not reviewed compared to the total patient population subject to review. The bill further specifies procedural requirements for the Secretary to carry out the required validation requirements in a more timely fashion. (Section 20)

2. The bill modifies the requirements pertaining to the composition of medical review teams in skilled nursing facilities so as to conform them with those requirements applicable to intermediate care facility review. (Section 20)

3. The bill would permit spouses of medicare beneficiaries aged 60–64 as well as certain other persons in that age group to buy into medicare at a premium rate equal to the cost of their protection. In order for such persons to be eligible to enroll for hospital insurance they must be enrolled for supplementary medical insurance. (Section 26)

4. The bill would authorize, under certain circumstances, reimburse-

ment to a Veterans' Administration hospital for care provided to a nonveteran medicare beneficiary. (Section 25)

5. The bill requires the Secretary of Health, Education, and Welfare to report to the Congress within 12 months after enactment of this legislation with an analysis and recommendations relating to all aspects (including the availability, administration, provision, reimbursement procedures and cost) of the delivery of home health services under medicare, medicaid and the title XX social services program. (Section 18)

Technician Revision

1. Your committee's bill clarifies existing law to insure that a power of attorney cannot be used to circumvent the prohibition in existing law against the use of "factoring" arrangements in connection with the payment of provider claims by the medicare and medicaid programs. (Section 2)

2. The bill modifies the provisions of existing law related to the rental or purchase of durable medical equipment to mandate that the Secretary requires the purchase of such equipment where purchase will be less costly than extended rental payments. (Section 16)

3. The bill increases individual State's incentives to adopt a computerized medicaid claims processing and information retrieval system by modifying one current requirement for higher Federal matching funds for the development and operation of this system. The bill would require such systems to provide explanation of benefits information to only a sample group of medicaid recipients rather than to each recipient as is currently required. (Section 10)

4. The bill would preclude Federal matching of State medicaid expenditures that result from State laws or contracts which exclude or limit insurance benefits because an individual is eligible for medicaid. (Section 11)

II. General Explanation of the Bill

Prohibition Against Assignment by Physicians and Others of Claims for Services; Claims Payment Procedures for Medicaid Program (Section 2)

The committee's bill would modify existing law to preclude the use of a power of attorney as a device to circumvent the existing ban on the use of "factoring" arrangements in connection with the payment of claims by the medicare and medicaid programs. The bill also requires State medicaid programs to provide for timely claims payment procedures.

In 1972, the Congress took action to stop a practice under which some physicians and other persons providing services under medicare and medicaid reassigned their medicare and medicaid receivables to other organizations or groups. Under the conditions of these reassignments, the organizations or groups purchased the receivables for a percentage of their face value, submitted claims and received payments in their name. By 1972, it had become apparent that such reassignments were a significant source of incorrect and inflated claims for services paid by medicare and medicaid. In addition, cases of fraudulent billings by collection agencies and substantial overpayments to these so-called "factoring" agencies were also found.

Congress concluded that such arrangements were not in the best interest of the government or the beneficiaries served by the medicare and medicaid programs. The Social Security Amendments of 1972, Public Law 92–603, therefore, included a prohibition against the payment for covered services to any one other than the patient, his physician, or other person who provided the service, unless the physician or other person is required as a condition of his employment to turn his fees over to his employer, or unless the physician or other person has an arrangement with a facility under which the facility bills for such services.

Despite these efforts to stop factoring of medicare and medicaid bills, some practitioners and other persons have circumvented the intent of the law by use of a power of attorney. The use of a power of attorney allows the factoring company to receive the medicare or medicaid payment in the name of the physician, thus allowing the continuation of program abuses which factoring activities were shown to produce in the past.

The committee bill would modify existing law to preclude the use of a power of attorney as a device for reassignments of benefits under medicare and medicaid, other than an assignment to a governmental entity or establishment, or an assignment established by or pursuant to the order of a court of competent jurisdiction. The bill also provides for similar prohibitions with respect to billings for care provided by institutions under medicare and medicaid. However, it would not preclude the agent of a physician or other person furnishing services from collecting any medicare or medicaid payment on behalf of a physician, provided the agency does so pursuant to an agreement under which the compensation paid the agency for his services or for the billings or collections of payments is unrelated (directly or indirectly) to the dollar amount of the billings or payments, and is not dependent upon the actual collection of any such payments. Thus, the use of billing agents by doctors and others, when the agents are paid on a basis related to the cost of doing business and not dollar amounts billed or collected, would not be precluded. The bill would not impose any limitations on the use of billing or collection agencies for payments owed by anyone other than the medicare or medicaid programs. Nor is it the committee's intention that this provision preclude the legitimate transfer of accounts receivable from these programs by an individual or an institution upon the "sale" of the individual's practice (for example upon retirement) or as part of the sale of all the assets of an institution.

The committee has received testimony indicating that undue delay in medicaid claims payments contributes to the rise of factoring arrangements as well as discourages physicians from participating in the program. The committee wishes to assure that the ban on factoring arrangements will not impose an undue hardship on medicaid practitioners. The bill therefore requires State medicaid plans to provide for claims payment procedures which ensure that 95 percent of clean claims (i.e. those not requiring further substantiation) of claims for services furnished by health care practitioners through individual or group practices or through shared health facilities are paid within 30 days of receipt; 99 percent of such claims must be paid within 90 days of receipt. State plans must further provide for procedures for prepayment and postpayment claims review. The bill permits the Secretary of Health, Education, and Welfare to waive this State plan requirement if he finds that a State has exercised good faith in trying to ensure timeliness and accuracy in its claims payment operation. Among other things the Secretary should take into account in making a waiver determination is whether the State has received an unusually high volume of claims which are not clean claims (i.e., claims for which no further written information or substantiation is required from the provider).

The amendments made by this section clarifying the ban on factoring arrangements shall apply with respect to care and services furnished on or after the day of enactment. The amendment pertaining to medicaid claims processing shall apply to calendar quarters beginning after June 30, 1978.

Disclosure of Provider Ownership and Financial Information (Section 3)

The committee's bill would require entities including health maintenance organizations (other than individual practitioners or groups of practitioners) providing services under medicare, medicaid, or the maternal and child health program and entities providing health-related services under title XX, such as homemaker, and home health agencies to disclose certain ownership interests, as a condition of program participation. These disclosure requirements would also be applied to medicare intermediaries and carriers and medicaid fiscal agents. Disclosure of additional ownership and financial information would be required, but only when specifically requested.

Current law and program policies already require the provision of certain ownership and financial information pertaining to entities providing services under medicare and medicaid. For example, an agreement with a provider of services under medicare may be terminated if the provider fails to furnish information necessary to validate the amount of payment claimed. In a different context, present law requires, as a medicare and medicaid condition of participation, a skilled nursing facility to disclose to the Secretary or appropriate State agency, and keep current, the name of anyone having significant ownership interest in the facility. Intermediate care facilities under medicaid are also required to disclose information on significant ownership interests.

The committee believes, however, that the information required under current law is often insufficient to facilitate the detection of fraudulent practices. Information now required does not provide adequate documentation on persons with significant ownership interests in more than one facility or other entity participating in medicare, medicaid, or the maternal and child health program or providing health-related services under title XX. Information is not specifically required to identify persons with significant ownership interests in related companies that supply goods and services to providers or other participating entities. Authority to obtain information on financial transactions with related suppliers or with subcontractors is not clearly defined in law.

To remedy these problems, the bill would require disclosure of specified ownership information to the Secretary or the appropriate State agency, as a condition of an entity's participation, certification, or recertification under medicare, medicaid, the maternal and child health program, or title XX. Entities required to disclose would be defined as: Medicare providers of services (as defined in section 1861(u), which includes hospitals, skilled nursing facilities, and home health agencies), independent clinical laboratories, renal disease facilities, health maintenance organizations meeting the requirements for participation in titles XVIII or XIX, and all entities (other than individual practitioners or groups of practitioners) that claim reimbursement for services provided under medicaid, the maternal and child health program, and, in the case of health-related entities, the social services program under title XX. In addition, the bill would require medicare intermediaries and carriers and medicaid fiscal agents to disclose specified ownership information as a condition of contract or agreement approval or renewal under titles XVIII and XIX.

The bill specifies that disclosing entities must supply full and complete information as to the identity of each person who:

(1) has a direct or indirect ownership interest of 5 percent or more in the entity,

(2) owns (in whole or part) a 5-percent interest in any mortgage secured by the entity,

(3) is an officer or director of the entity, if it is organized as a corporation, and

(4) is a partner in the entity, if it is organized as a partnership.

Where disclosing entities providing services under medicare or medicaid own 5 percent or more of a subcontractor, similar ownership information would be required to be disclosed about the subcontractor.

In addition, the bill would require, to the extent feasible, that information about a person's ownership disclosed by an entity must also include information with respect to ownership interest of that person in any other entity which is required to comply with disclosure requirements under the bill.

The bill would also modify the existing provisions of title XVIII and XIX which relate to termination of medicare provider agreements or suspension of medicaid payments to health care entities (other than individual practitioners and groups of individual practitioners) by adding two additional requirements. The bill would require a provider entity to comply with specific requests addressed to it by the Secretary or the State medicaid agency for full and complete information on: (1) the ownership of any subcontractor (as defined in regulations) with whom the provider has annual business transactions of more than $25,000, and (2) any significant business transactions (as defined in regulations) between it and any subcontractor or between it and any wholly owned supplier.

In developing regulations to define subcontractors and suppliers, the committee intends that a distinction be made between agencies and organizations from which a provider only purchases goods and services to assist in meeting its obligations to patients and those agencies and organizations to which a provider has actually delegated some of the duties and obligations it has directly to its patients. Although the facts and circumstances of individual situations may differ, it is contemplated under such a delineation that the relationship between a hospital and a commercial laundry would be considered to be that of a provider and its supplier, but that the relationship between a hospital and a management company with which it has contracted to administer either all or part of the day-to-day operations of the institution or the relationship between a hospital and an independent radiological service would be that of a provider and a subcontractor.

The bill specifies that the Secretary is to determine by regulation the meaning of the phrase "directly or indirectly" with respect to persons having ownership interests in disclosing entities. In directing him to do this, the committee is acutely aware of the difficulties involved in developing this definition, particularly when the phrase "persons with ownership interests" is interpreted to mean a corporation. Institutional providers of health care often are owned by corporate entities which in turn are owned by other corporations. In order to compile accurate information on persons with ownership interests in disclosing entities, the committee believes it is also necessary to obtain information on persons with ownership interests in these other corporations. The information to be disclosed under the bill must go beyond the listing of corporate identities unless that corporation is already subject to ownership disclosure under the statutes administered by the Securities and Exchange Commission or other Federal regulatory agencies. It is intended, at the minimum, to identify those persons with ownership interests of 5 percent or more in a nonpublicly held corporation that owns a disclosing entity. In addition, the Secretary may determine that it is necessary to require disclosure of persons with ownership interests in nonpublicly held corporations beyond the first level of corporate ownership where the concept of "pyramiding" of corporate structures appears to be present.

The committee views the disclosure requirements imposed by the bill to be of critical importance in the process of detecting and deterring fraudulent and abusive practices within the medicare, medicaid, the maternal and child health and the social services programs. The committee does not intend, however, for these requirements to be unduly burdensome on providers and other entities to which they apply. The provisions were designed to be incorporated into the ongoing certification or contractual process. It is, therefore, expected that their implementation and administration will be accomplished in such a way as to preclude unnecessary additional administrative burdens on those complying with them.

The amendments pertaining to ownership disclosure would apply with respect to certifications and recertifications made (and participation in the programs pursuant to certifications and recertifications made) and fiscal intermediary agreements or contracts entered into or renewed on and after the date of enactment. The remaining amendments would take effect on the date of enactment except for the provision requiring disclosure of information on subcontractors and significant business transactions under medicaid which would become effective January 1, 1978.

Penalties for Defrauding Medicare and Medicaid (*Section 4*)

The committee bill would strengthen and clarify the penalty provisions in existing law which relate to persons providing services under medicare and medicaid. The bill would also add a penalty for medicare providers, physicians, and other suppliers of services who have agreed to accept an "assignment of benefits" under part B of the medicare program but repeatedly charge patients in excess of the "reasonable charge". The bill further requires the Inspector General to include an evaluation of the performance of the Attorney General in the investigations of criminal violations relating to medicare and medicaid in his annual report.

Existing law provides specific penalties under the medicare and medicaid programs for certain practices that have long been regarded by professional organizations as unethical, which are unlawful in some jurisdictions, and which contribute significantly to the cost of the programs. Such practices as the submission of false claims, or the soliciting, offering, or acceptance of kickbacks or bribes, including rebates or a portion of fees or charges for patient referrals, are misdemeanors under present law and punishable by a maximum $10,000 fine, up to 1 year imprisonment, or both. In addition, the making of false statements with respect to material facts concerning the conditions of health care facilities in order to qualify for certification under medicare and medicaid is considered a misdemeanor and punishable by a maximum $2,000 fine, up to 6 months in prison, or both.

Recent hearings and reports, however, indicate that such penalties have not proved adequate deterrents against illegal practices by some individuals who provide services under medicare and medicaid. In addition, these misdemeanor penalties appear inconsistent with existing Federal criminal code sanctions which make similar actions punishable as felonies. Also, it has been brought to the attention of the committee by U.S. attorneys' offices which have utilized these Social Security Act sanctions in the prosecution of medicare and medicaid fraud cases that the existing language of these penalty statutes is unclear and needs clarification.

The bill would strengthen the penalty provisions in existing law which relate to persons providing services under medicare and medicaid. Most fraudulent acts now classified as misdemeanors would become felonies. Penalties for these acts would be increased to a maximum $25,000 fine, up to 5 years imprisonment or both.

In addition, the bill would clarify and restructure those provisions in existing law which define the types of financial arrangements and conduct to be classified as illegal under medicare and medicaid.

It would make subject to the penalty provisions any person who solicits or receives any remuneration (1) in return for referring an individual to a person for the furnishing, or arranging for the furnishing of items or services; or (2) in return for purchasing, leasing or ordering, or arranging for, or recommending the purchasing, leasing, or ordering of goods, facilities, or services. Also, any person who offers or pays any remuneration to any person to induce such person to do similar activities would be subject to the penalty provisions.

The bill would define the term "any remuneration" broadly to encompass kickbacks, bribes, or rebates which may be made directly or indirectly, overtly or covertly, in cash or in kind. The term would exclude any amount paid by an employer to an employee for employment in the provision of covered items and services if such employee has a bona fide employment relationship with the employer. The committee has specified that the employment relationship must be bona fide to insure that other arrangements involving the payment of a salary or related benefits will not be excluded from the definition of "any remuneration".

The bill would specifically exclude the practice of discounting or other reductions in price from the range of financial transactions to be considered illegal under medicare and medicaid, but only if such discounts are properly disclosed and reflected in the cost for which reimbursement could be claimed. The committee included this provision to ensure that the practice of discounting in the normal course of business transactions would not be deemed illegal. In fact, the committee would encourage providers to seek discounts as a good business practice which results in savings to medicare and medicaid program costs.

In addition, the committee bill would allow States to suspend, for a period not to exceed 1 year, the eligibility of medicaid recipients convicted of defrauding the program. However, the misdemeanor penalty provision presently provided under existing law for conviction of such individuals would be retained (maximum fine of $10,000, up to 1 year imprisonment, or both) as would be the penalty for conviction of a beneficiary under the medicare program.

Under present law, a physician who wishes to be paid directly by the medicare program must accept an assignment, i.e., he must agree to accept the program's reasonable charge as payment in full. Thus, he is agreeing to bill the beneficiary for no more than any unmet deductible amount and for the 20 percent of the reasonable charges that is not paid by the program. Breaches of assignment by physicians who charge beneficiaries more than the agreed-upon amount are treated under the law as a form of program "abuse." Unlike fraudulent acts, abuses are not subject to civil or criminal penalty even when the physician has acted willfully and knowingly. Breach of assignment is the most frequent form of abuse in medicare. Of the 23,000 complaints to date about program abuses by the program's beneficiaries, about half concerned physicians' failure to live up to the assignment agreement. The option to use the assignment procedure has been withdrawn from some 250 physicians who have been persistent offenders.

The committee believes that stronger measures are needed to deter physicians from violating their assignment agreements and that more severe sanctions should be available for dealing with persistent offenders. Therefore, the committee bill would make willful and repeated assignment violations a misdemeanor, subject to a fine of not more than $2,000 and/or a prison term of not more than 6 months.

In its consideration of this and related legislation bill, the committee has focused considerable attention on the activities of the Department of Justice to investigate and prosecute fraud in the medicare and medicaid programs. The committee believes that the Department must develop the resources to combat this complex type of criminal activity. The Attorney General has made a commitment to strengthen departmental efforts in this area and intends to monitor those efforts quite closely. The letter of the Attorney General to the Chairman of the Health Subcommittee of the House Ways and Means Committee outlining departmental initiatives in this area follows:

OFFICE OF THE ATTORNEY GENERAL,
Washington, D.C., May 12, 1977.

Hon. DAN ROSTENKOWSKI,
Chairman, Subcommittee on Health, Committee on Ways and Means, House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: I am writing you again with reference to the proposal to include in H.R. 3 a mandate for the establishment of a separate and identifiable organizational unit within the Department's Criminal Division to carry out specified functions relating to investigation and prosecution of criminal violations in the programs of health insurance and medical assistance provided under the Social Security Act. As I indicated in my appearance before your subcommittee, I fully concur in the need for vigorous investigation and prosecutions of fradulent activities in the medicare-medicaid program. I strongly feel, however, that the aforementioned provision is unnecessary and would set an undesirable precedent by dictating in law a particular subordinate organization within the Criminal Division.

In recognition of the importance of taking effective action against medicare-medicaid abuses, we are currently taking the following steps.

1. We have within the Fraud Section of the Criminal Division a program fraud unit which coordinates Department efforts directed against program abuse and maintains regular liaison with program agencies including HEW.
2. We are currently working on preparation of a Medicaid Enforcement Manual for distribution to Assistant United States Attorneys to assist them in prosecuting medicaid-medicare cases.
3. We are meeting on a regular basis with the Inspector General and his staff of HEW in an attempt to develop strategies and enforcement priorities within medicaid-medicare areas.
4. There is a separate program fraud unit within the Public Integrity Section which focuses on situations involving corruption of government officials in the administration of programs.
5. We are attempting to identify significant cases in order to insure that ample resources are devoted to their development and prosecution.
6. Many of the larger of the U.S. attorneys offices, including the southern district of New York and Chicago, have established separate program fraud units within the district to focus on these types of offenses.

I have every intention of continuing emphasis in this area. I do respectfully recommend, however, against placing in the law the requirement of a specific organization entity for this purpose. I am afraid that other congressional committees will feel that they must support similar organizational requirements in law for their programs to insure that such programs receive appropriate attention. A proliferation of special units would inevitably lead to confusion, lack of flexibility and be self-defeating of the purposes intended.

Sincerely,

GRIFFIN B. BELL, *Attorney General.*

The committee bill modifies section 204(a) of Public Law 94–505, relating to the annual reports of the Health, Education, and Welfare Inspector General, to require the Inspector General's report to include an evaluation of the performance of the Attorney General in the investigation and prosecuting of criminal violations relating to fraud in the medicare and medicaid programs and include any recommendations with respect to improving the performance of such activities.

The penalty provisions of this section would apply with respect to acts occurring or statements or representations made on or after the date of enactment.

Amendments Related to Professional Standards Review Organizations (Section 5)

Waiver of Other Review Requirements (Section 5(a))

The committee's bill provides that where the Secretary finds a given Professional Standards Review Organization (PSRO) competent to perform required review functions, similar activities otherwise required by law would not apply, except to the extent specified by the Secretary.

Under present law, the Secretary is authorized to waive any or all of the review, certification, or similar activities otherwise required under the law where he finds, on the basis of substantial evidence of the effective performance of review and control activities by PSRO's, that the activity or activities are no longer needed for the provision of adequate review and control. The purpose of this provision was to avoid duplication of review functions. Current law does not specifically state that the waiver authority is applicable to conditionally designated organizations, although the language has been interpreted to permit such actions.

The bill would both clarify present law and simplify its application by providing that where the Secretary makes a formal determination that a given PSRO is competent to perform required review functions, the review, certification and similar activities otherwise required by law would not be applicable with respect to those providers, suppliers, and practitioners being reviewed by such PSRO, except to the extent specified by the Secretary. A finding by the Secretary under this subsection could be made both with respect to conditionally designated and qualified PSRO's. The provision would not affect other provisions of existing law relating to determinations with respect to conditions for eligibility to or payment of benefits (as distinct from reviews or certifications of medical necessity).

The amendments made by this subsection would be effective upon enactment.

Modification of Requirements for Conditionally Designated PSRO's (Section 5(b))

The committee's bill extends the time period for conditional designation of PSRO's and clarifies the language of present law pertaining to the duties and functions a PSRO must assume during this trial period.

Current law provides that each PSRO shall initially be designated on a trial basis for a period not to exceed 2 years. By the end of the period, the organization shall be considered a qualified organization only if the Secretary finds that it is substantially carrying out in a satisfactory manner the functions required of a PSRO with respect to institutional services in its area. When the legislation was enacted, it was anticipated that conditionally designated organizations would be able to assume review responsibilities with respect to all institutional services within a 2-year period. Implementation of the program has been slower than anticipated with the major focus to date on review of inpatient hospital services. A number of conditionally designated organizations have or are approaching the end of their 2-year trial period. While many are effectively performing reviews of services, they are technically not eligible for continuation of their conditional status or designation as qualified organizations.

The bill modifies the conditional designation provision of present law to provide for a conditional period not to exceed 48 months. The Secretary would be authorized to extend this period for an additional 24 months if an organization has, for reasons beyond its control, been unable to satisfactorily perform all of its required functions. The committee expects that this extension of the conditional period would be authorized only in unusual circumstances.

The bill also clarifies the requirement of present law that PSRO's must assume responsibility for review of all institutional services (including ancillary services) during the conditional period. Additionally, the bill clarifies the requirement that PSRO's must be reviewing long-term institutional care services (subject to the provisions of section 5(d) which leave the responsibility for review of services in an intermediate care facility where such a facility is not also a skilled nursing facility with the State medicaid agency unless the Secretary finds the State is not performing effective review).

The amendments made by this subsection would be effective upon enactment.

Review Requirements (Section 5(c))

The committee's bill requires the Secretary to give priority to PSRO requests to review services provided in "shared health facilities"; requires a PSRO to undertake ambulatory care review not later than 2 years after it has achieved operational status (but the Secretary may not require a conditional PSRO to undertake such ambulatory care review); and modifies the language in current law pertaining to physicians excluded from participation in review activities.

Under current law, a PSRO is required to review only care provided by or in institutions. It may request authority to review other kinds of health services, and the Secretary may approve the request at his option. To date, little emphasis has been given to the assumption of review responsibility by PSRO's for other kinds of health care services.

The bill would require the Secretary to give priority to requests by PSRO's to review services in "shared health facilities" with the highest priority being assigned to requests from PSRO's located in areas with substantial numbers of such facilities. A "shared health facility" is defined as an arrangement meeting all of the following criteria:

(1) Two or more practitioners practice their professions at a common physical location;

(2) The practitioners share common space, services of supporting staff or equipment;

(3) The practitioners have a person (who may himself be a practitioner), paid on a percentage or other basis clearly unrelated to the value of the services provided, who either is in charge of or supervises substantial aspects of the operation or who makes available services of supporting staff who are not employees of such practitioners; and

(4) At least one of the practitioners receives from medicare, medicaid, and maternal and child health fee-for-service payments in excess of $5,000 for one month or $40,000 for 12 months.

The term "shared health facility" specifically excludes hospitals, skilled nursing facilities, home health agencies, federally approved health maintenance organizations, hospital cooperative shared services organizations meeting the requirements of section 501(e) of the Internal Revenue Code, or any public entities.

The definition of a "shared health facility" is designed to distinguish those types of ambulatory facilities (sometimes referred to as "Medicaid Mills") which are characterized by a high volume of services to medicaid patients (often of an excessive or unnecessary nature), and the payment of a percentage of the medicare and medicaid billings to the owner or manager of the facility, from legitimate group practice arrangements under which several practitioners render services at a common location. Since a shared health facility could evade the test of percentage arrangements, the Secretary has leeway to determine whether the payments to the owner or manager, while technically not a percentage of billings, are clearly unrelated to the value of the services provided by such person to the facility. By requiring a facility to meet all four criteria specified in the bill, it is expected that such legitimate arrangements among practitioners would be excluded from the definition. The committee expects, therefore, that the Department will exercise judgment in applying this definition so as to assure that legitimate group practice arrangements are not inappropriately classified.

Recent congressional hearings and reports have documented widespread instances of fraud and abuse in certain types of ambulatory facilities which have come to be known as Medicaid Mills. The definition of shared health facilities is designed to identify these specific types of arrangements in order to facilitate PSRO review of the services furnished by such facilities. Committee wishes to emphasize that a PSRO is not a fraud detection organization; its role is to render professional determinations as to the medical necessity and appropriateness of services. Thus, a PSRO will be expected, where it chooses to undertake review of services furnished by "shared health facilities," to review those services for the same purposes—to judge appropriateness and quality—that it would review services provided in other health care settings.

Under current law, PSRO's may request authority to review ambulatory care services, i.e., those provided in clinics or doctors' offices, however, to date, little emphasis has been given to this type of review. The committee bill would require the Secretary to approve a request by a PSRO (whether under conditional or operational status) to undertake ambulatory review if the Secretary finds it capable of performing this function. The bill further directs the Secretary, where he finds an operational PSRO (not a conditional PSRO) capable, to require such organization to undertake ambulatory review not later than 2 years after it has achieved operational status. The committee expects that in implementing this requirement, the Secretary will exercise judgment with respect to the varying capacities of PSRO's and, where appropriate, will establish a reasonable classification of ambulatory care review activities for an organization to undertake. Such classification might include specific categories of services or specific aspects of various service categories. The committee further notes that "ambulatory care services" are those services not rendered by or in an institution. Institutional review, including review of services provided in hospital outpatient departments or emergency rooms, is a requirement of current law and must be conducted before an organization can achieve operational status.

Under current PSRO review provisions, a physician is precluded from reviewing health services provided to a patient if he was directly or indirectly involved in providing the services. Present law further precludes review by a physician of services furnished in any institution, organization, or agency if he or any member of his family has, directly or indirectly, any financial interest in such entity.

The bill would modify these restrictions to permit greater opportunity for physicians participation in PSRO review activities. Under the bill, a physician would not be permitted to review services for which he was directly responsible (rather than directly or indirectly responsible as in present law) or services in an institution in which he or a member of his family has a "significant" financial interest (rather than "any" financial interest, as in present law). The committee expects that in implementing this provision, HEW will employ the same definition of "significant" financial interest as is currently used in administering medicare.

The bill further clarifies that the contractual relationship between the Government and a PSRO is one of assistance rather than procurement. The major thrust of an agreement with a PSRO is not the procurement of services but rather a determination by the Secretary that the PSRO is authorized to carry out the functions prescribed by law. The fiscal aspects of the agreement are intended as assistance to the PSRO in the performance of its functions. The term "assistance agreement" is intended to permit the flexibility which an assistance arrangement allows rather than to require the procurement contract approach in reimbursing PSRO's for carrying out the functions vested in them by statute pursuant to a designation by the Secretary.

The amendments made by this subsection would be effective upon enactment.

Conclusive Determinations for Payment (Section 5(d))

The committee's bill provides that where a PSRO has been found competent by the Secretary and is performing specific review functions, medical determinations made in connection with such review shall be considered conclusive on those issues for purposes of payment. The bill provides a formal role for the States in the process of establishing and evaluating PSRO review of services provided through the medicaid program;

The bill generally precludes delegated review in skilled nursing facilities and provides that review of services provided in intermediate care facilities (which are not also skilled nursing facilities) will be undertaken by a PSRO only if the Secretary finds that the State is not performing effective review in these facilities.

Under present law, medicare payments and the Federal share of medicaid payments may not generally be made for health care services which a PSRO, in the proper exercise of its duties, has determined to be medically unnecessary or inappropriate. However, the committee believes that it is necessary, in order to avoid the performance of disruptive duplicative reviews by medicare and medicaid agencies, to clarify the scope of the PSRO's authority and the role of the medicaid State agencies.

Accordingly, the bill provides that where a conditionally designed or a qualified PSRO has been found competent by the Secretary to assume specific review responsibilities and is performing such reviews, a determination as to quality or necessity made in connection with such review would constitute the conclusive determination on those issues for purposes of payment. (Such determinations would be subject to the hearings and appeals provisions of present law.) Medicare fiscal intermediaries and State medicaid agencies would continue to be responsible for other types of reviews and determinations relating to program eligibility, coverage of services, audit, claims payment, fraud and abuse detection, and related activities.

The committee has received comments from a number of States expressing concern over the potential impact of PSRO determinations on State medicaid budgets. The committee has concluded that since substantial State monies are involved it is appropriate that they be given an opportunity to evaluate a PSRO's capability to efficiently and effectively perform review of medicaid services. The bill, therefore, makes provision for the participation of States in the PSRO designation process and in the ongoing monitoring of PSRO review activities.

The bill requires a PSRO to consult with the medicaid State agency in the development of its formal review plan (required as a condition for designation) and in any modification of the plan involving assumption of review responsibility for additional categories of services. The bill provides the States with an opportunity to review and comment on the proposed conditional designation of a PSRO, the change in designation status from conditional to operational, and the assumption by the PSRO of responsibility for long-term care and ambulatory care review. Before the Secretary designates a PSRO or substantially adds to its functions, he is required to take the State's views into account. If his decision differs from the course recommended by the State, he must notify the State of the reason for his decision and allow it additional time to provide further support for its views.

The bill provides that a PSRO's determination shall constitute a conclusive determination for purposes of payment under medicaid only if the PSRO has entered into a memorandum of understanding (approved by the Secretary) with the appropriate State medicaid agency. The purpose of this memorandum is to delineate the relationship between the PSRO and the State agency. The requirement for a memorandum of understanding may be waived only if the State indicates that it does not wish to enter into such an understanding or if the Secretary finds that the State agency has refused to negotiate in good faith or in a timely manner with the PSRO involved.

A State medicaid agency may request a PSRO to include in its memorandum of understanding a specification of review goals and methods (in addition to those required in the PSRO's formal review plan) for the performance of its required functions. If the State medicaid agency and the PSRO are unable to agree on the inclusion of such items, the Secretary would review the requested specification and require that it be included in the memorandum if he determines that the review goals and methods are consistent with titles XI and XIX of the act and do not impair the effectiveness and uniformity of aid. For example, a State might request that a PSRO emphasize the the PSRO's review of health care services under medicare and medic- prevention of unnecessary Friday admissions of medicaid patients for elective procedures not scheduled to be performed until Monday. Your committee notes that the PSRO's application of norms, criteria, and standards would not be affected by this provision; standards for quality, appropriateness and necessity of services would continue to be the same for both programs. If the PSRO found review of weekend admissions was appropriate, it would generally be applied to all patients whose care was reviewed by the PSRO.

The committee intends that the Secretary shall not deny a State agency request solely because the PSRO has not been utilizing such a requested method or goal for the medicare program or because the PSRO cannot apply the method or goal to the medicare program due to differences in the patient populations. Rather, the committee intends that where differences in the patient populations do not preclude uniform review by the PSRO, the Secretary's decision shall be based on his determination as to whether the PSRO can effectively apply such review methods or goals to the review of services provided under both the medicare and medicaid programs in order to ensure that the uniformity of PSRO review under the Social Security Act can be maintained.

The committee intends that any review specified by the State agency which the PSRO performs in accordance with its memorandum of understanding with the agency and pursuant to its review authority under title XI would be fully federally funded. In addition, the bill provides regular Federal matching if a medicaid State agency contracts with a PSRO to undertake additional review responsibilities, provided the State agency formally requests it and the performance of such responsibilities is provided for in an approved medicaid plan amendment. For example, the State agency may request the PSRO to approve so-called administrative days, such as an additional day of hospital stay which may be required because there is no immediately available skilled nursing facility bed.

The bill also provides Federal financial participation to State medicaid agencies for the costs of monitoring the performance of review activities by PSRO's under State monitoring plans which have been approved by the Secretary. It is expected that the Secretary will develop criteria for approval of such plans and that they will not be approved where the proposed monitoring activities duplicate the purposes of PSRO review. The State medicaid agency may include in its plans for monitoring a specification of the performance criteria for judging PSRO effectiveness. Inclusion of such specifications in the State's monitoring plan is not mandated because it is believed that most States during the development and initial implementation of State monitoring of PSRO review will not have such performance criteria developed. However, at such time as the State agency intends to utilize performance criteria for judging PSRO review effectiveness, the committee expects the agency to discuss the criteria with the PSRO and to amend the State's monitoring plan to include the agreed-upon criteria.

The bill authorizes the State agency to request suspension of the PSRO's authority to make conclusive determinations if in the course of its monitoring activities it develops reasonable documentation that the PSRO review determinations are not consistent with quality and appropriateness of medical care and services and have caused an unreasonable and detrimental impact on total State medicaid expenditures. The Secretary is required to determine the reasonableness of the State's complaint within 30 days of receipt of the documentation. Upon a finding of reasonableness, the Secretary may suspend all or part of the PSRO's conclusive determination authority under medicaid. (For example, he may suspend its review of long-term care services, but not hospital services. He may also take similar action with respect to PSRO determinations under medicare if he determines such action is appropriate.) The committee expects that where the substance of a State's complaint can be and is promptly corrected a suspension action would not be taken. The committee bill further provides that the Secretary may suspend immediately all or part of a PSRO's conclusive determination authority if he makes his own finding that such entity is not performing its functions in a reasonable and appropraite manner. Any suspension actions taken by the Secretary (either in response to a State's complaint or as a result of his own evaluation) or any determination by the Secretary that a suspension is not in order shall not be subject to judicial review. During any suspension period the Secretary is required to conduct a reevaluation of the PSRO's capability to perform review activities and to inform the appropriate agencies, organizations, and congressional committees of any documentation submitted and actions taken.

The bill requires the Secretray to establish procedures and mechanisms governing his relationship to State agencies in connection with their respective responsibilities concerning memoranda of understanding, monitoring, and reevaluations. The Secretary is required to periodically consult with representatives of State agencies and PSRO's. Further, the appropriate State medicaid agency is permitted to be represented on any project assessments conducted by the Secretary. The committee intends that the procedures and mechanisms developed by the Secretary shall promote smooth working relationships between all parties involved and shall involve a minimum of disruption in the orderly implementation of the PSRO program. The committee further intends that State monitoring activities will become less intensive over time (particularly with respect to PSRO's which are no longer in conditional status) and will focus on problem areas which have been detected in the performance of PSRO review.

The committee is aware of the fact that as PSRO's begin to review services provided in institutional settings other than hospitals, different requirements may be appropriate. Accordingly, the bill generally prohibits delegated review in skilled nursing facilities since these facilities have generally had far less experience in conducting in-house review activities than hospitals. This prohibition would not be applicable in cases where a skilled nursing facility is a distinct part of a hospital. The committee bill specifies that PSRO-delegated review to a hospital also encompasses an attached skilled nursing or intermediate care facility.

The committee bill further provides that PSRO's shall have responsibility for the review of services provided in an intermediate care facility where such facility is also a skilled nursing facility. PSRO review of care in other intermediate care facilities and public institutions for the mentally retarded (services which are paid for only under the medicaid program) would only be undertaken where the Secretary determines that the State is not performing effective review of the quality and necessity of services provided in such facilities. If the Secretary does make such a finding, and the PSRO is required to carry out the review, the committee expects that the PSRO would not delegate review to the intermediate care facility, just as they are prohibited from such delegation to skilled nursing facilities.

The amendments made by this subsection would be effective upon enactment.

Clarification of Sanctions Provision (Section 5(e))

Current law specifies those conditions under which the Secretary may, at the recommendation of a PSRO, withdraw a medical care provider's eligibility to participate in Social Security Act medical care programs where it is determined that it is not willing, or cannot, carry out its obligations to order and provide only necessary care of acceptable quality.

The committee bill makes clear that the provision in question applies to any health care practitioner, or any hospital or other health care facility, agency, or organization which is subject to PSRO review.

The amendment made by this subsection would be effective upon enactment.

National Council (Section 5(f))

The bill provides for staggered terms for members of the National Professional Standards Review Council.

Present law provides that the 11 members of the Council shall be appointed for 3-year terms and may be eligible for reappointment. The bill would amend this provision. The general term for Council members would continue to be 3 years, except that for members appointed in 1977, four shall be appointed for a 2-year term and three for a 1-year term. All members would continue to be eligible for reappointment.

The amendment made by this subsection would be effective upon enactment.

National Council Report (Section 5(g))

The committee bill would delete the requirement in present law for an annual report on its activities by the National Professional Standards Review Council and would require instead the submission by the Secretary of a detailed annual report on the PSRO program.

Under the new reporting requirement included in the bill, the Secretary would be required to submit substantially more information concerning the cost and operation of the PSRO program than has previously been required of the National Council. Accordingly, the bill would delete the requirement for the National Council report as duplicative and unnecessary.

The amendment made by this subsection would be effective upon enactment.

Exchange of Data and Information With Other Agencies (Section 5(h))

The committee's bill would expand and clarify the circumstances under which the provision of data or information by PSRO's would not violate the confidentiality requirement of law.

Under present law, any data or information acquired by a PSRO in the exercise of its duties must be held in confidence and may not be disclosed to any person except (1) to the extent that may be necessary to carry out the purpose of the PSRO provisions, or (2) in such cases and under such circumstances as the Secretary shall by regulations provide to assure adequate protection of the rights and interests of patients, health care practitioners, or providers of health care. Interim regulations issued by the Department on December 3, 1976, provide for the disclosure of two types of information acquired by the PSRO:

1. Data and information acquired by the PSRO: (a) which has been published; (b) which has not been identified by the source as confidential; and (c) whose disclosures are not otherwise prohibited by law.
2. Summary statistics aggregated from the Uniform Hospital Discharge Data Set (UHDDS) to the extent that it is not identifiable to an individual patient or health care practitioner.

The bill would expand and clarify those circumstances under which the provision of data or information would not violate the confidentiality provisions to include: (1) provision of data or information by the PSRO, on the basis of its finding as to evidence of fraud or abuse, to Federal or State agencies recognized by the Secretary as having responsibility for the identification or detection of fraud and abuse activities; such data and information may be provided at the request of the recognized agencies at the discretion of the PSRO; and (2) provision of aggregate statistical data to agencies having responsibility for health planning and related activities under Federal or State law. The data and information furnished to the planning agencies would be provided in the format and manner prescribed by the Secretary or agreed upon by the agencies and the PSRO. Such data and information would be in the form of aggregate statistical data on a geographic, institutional, or other basis reflecting the volume and frequency of services furnished and the demographic characteristics of the population whose services are subject to review by the PSRO. However, the data would not identify any individual.

Data and information made available to Federal or State agencies recognized by the Secretary as having responsibility for identifying and investigating fraud and abuse may not be further disclosed except when the disclosure is made in the course of a legal, judicial, or administrative proceeding. Violation of this prohibition would result in application of the penalty specified in existing law.

The committee has included this provision to facilitate the exchange of data and information with other agencies while at the same time assuring that the confidentiality of patient records will not be violated. The committee has received information that PSRO's which have identified suspected cases or widespread patterns of fraud and abuse have been unable to make the information available to enforcement agencies. The committee also notes that the provision of aggregate statistical data to Federal and State planning agencies will enable those bodies to develop a more accurate picture of medical care patterns in their areas, facilitate planning for future resource needs, and prevent unnecessary duplicative data gathering activities.

The bill also includes a provision to protect patient records from subpena or discovery proceedings in a civil suit. This provision, however, would not preclude the subpena or discovery of originals or copies of the same documents in the possession of others.

The amendment made by this subsection would be effective upon enactment.

Legal Expenses (Section 5(i))

The committee's bill provides for payment of legal fees in connection with the defense of suits brought against a PSRO related to the performance of its functions. The bill would authorize the Secretary to assume responsibility for legal fees incurred in connection with the defense of any suit, action, or proceeding brought against the PSRO or any of its members or employees related to the performance of its functions. While all PSRO's currently have liability insurance which covers such attorneys' fees, this provision would serve as an additional guarantee in the event such insurance is subsequently withdrawn.

The amendment made by this subsection shall be effective upon enactment.

Payment of PSRO Expenses (Section 5(j))

The committee's bill would clarify the intent of present law that payment for PSRO expenses is to be made from Federal funds.

Under present law, expenses incurred by PSRO's are payable from medicare trust funds and from funds appropriated to carry out the other health care provisions of the Social Security Act. The bill would clarify that it is not intended that States or local governmental entities contribute toward these expenses, as they normally must do to receive Federal matching funds under title XIX.

The amendment made by this subsection would be effective upon enactment.

Annual Reports (Section 5(k))

Current law does not require the preparation of a detailed report on the activities, cost, and impact of the PSRO program. The committee believes that this information is necessary to determine the status of program operations, to evaluate the progress of program implementation, and to assess the program's effectiveness.

The bill committee therefore requires the Secretary to submit annual reports to the Congress by April 1 of each year beginning in 1978 on the administration, impact, and cost of the PSRO program during the preceding fiscal year. The reports must include program data on each PSRO; institutions and practitioners whose services are subject to review; penalties and sanctions; total costs under titles V, XI, XVIII, and XIX in the implementation of all required review procedures; changes attributable to PSRO activities; results of program evaluation activities; extent to which PSRO's are performing reviews for other private or governmental programs; and legislative recommendations.

The amendment made by this subsection would be effective upon enactment.

Medical Officer (Section 5(l))

The bill would include medical officers in American Samoa, the Northern Mariana Islands and the Trust Territory of the Pacific Islands in the PSRO program. In these areas medical officers rather than doctors of medicine provide medical care. The bill would therefore permit medical officers licensed to practice medicine in these localities to participate in the PSRO program. These individuals may not, however, serve on the National Council or make any final determinations with respect to medical necessity or appropriateness of care provided by a duly licensed doctor of medicine or osteopathy.

The amendment made by this subsection would be effective upon enactment.

Payment for Review of Part B Services Provided by Hospitals (Section 5(m))

Public Law 94–182, enacted on December 31, 1975, included an amendment to the medicare program which was designed to equalize reimbursement for PSRO hospital review activities whether such review was carried out by a hospital under delegation from a PSRO or by the PSRO itself. Previously, only delegated review activities could be funded out of the medicare trust funds. Under the new law, PSRO expenses in carrying out nondelegated review for hospital services covered under medicare part A or medicaid or the maternal and child health program would also be reimbursed through this mechanism. The law did not, however, provide for similar funding for PSRO review of hospital services covered under medicare part B.

Accordingly, the bill corrects this oversight by providing that funding for delegated review activities for services provided by a hospital which are covered under medicare part B shall be made from the medicare trust funds.

The amendment made by this subsection would be effective upon enactment.

Statewide Councils (Section 5(n))

The bill extends the protection currently provided to members and employees of a PSRO from criminal prosecution or civil liability when carrying out PSRO functions to members and employees of Statewide Professional Standards Review Councils.

The amendment made by this subsection would be effective upon enactment.

Technical Corrections (*Section 5(o)*)

The committee bill makes technical corrections in sections 1152(b)(1)(A), 1155(a)(1), and 1160(b)(1) of the act.

Physician Review (*Section 5(p)*)

The committee bill deletes the current law distinction, based on whether a hospital has or has not been delegated PSRO review, in determining those physicians who may be responsible for review activities.

Under current PSRO review provisions, a physician is ordinarily prevented from being responsible for the review of hospital care and services provided in any hospital in which he has active staff privileges when the review of such services has not been delegated to the hospital by a PSRO. However, where review has been delegated to the hospital, a physician with active staff privileges in that facility may be responsible for the review.

The committee notes that there is no evidence that such a distinction in the qualification of the physician responsible for the review is necessary. The decision whether or not to delegate review is not necessarily related to the ability of an individual physician with active staff privileges in a particular hospital to do the required review, but is more likely to be related to other factors. The committee has concluded that the existing prohibition places an undue burden on nondelegated hospital review.

The committee bill therefore deletes the restriction contained in current law which ordinarily prevents physicians with active staff privileges in a hospital from being responsible for review in a facility if review responsibilities have not been delegated.

Issuance of Subpenas by the Comptroller General (*Section 6*)

The bill would give the Comptroller General of the United States the power to sign and issue subpenas to gain information regarding programs authorized under the Social Security Act.

Currently, the Comptroller General of GAO does not have the statutory authority, under the Social Security Act, to issue subpenas in connection with GAO investigations into programs authorized by that act. In a December 29, 1976, letter to the House Ways and Means Committee, which was in response to an inquiry concerning Social Security Act subpena power for the General Accounting Office, the Acting Comptroller General stated that:

> From the overall perspective, we believe that the subpena power in question would be a useful tool. In all probability, the mere existence of such a power would be sufficient to preclude problems in most cases and, in our opinion, resort to its use would be relatively infrequent. We would thus favor the inclusion of subpena authority in the anticipated new legislation.

The bill would give the Comptroller General of GAO the power to sign and issue subpenas in order to gain information and facilitate review of programs authorized under the Social Security Act particularly with respect to investigations of fraudulent and abusive practices. In connection with GAO's statutory functions including investigations, examinations, and auditing, subpenas could be issued to gain access to pertinent books, records, documents, or other information.

Under resistance or refusal by an individual to obey a subpena, the bill would authorize the Comptroller General to request a court order requiring compliance.

The amendments made by this section would be effective upon enactment.

Suspension of Practitioners Convicted of Medicare- or Medicaid-Related Crimes (Section 7)

The committee's bill requires the suspension of physicians or other individual practitioners from participation in medicare or medicaid if such practitioner has been convicted of a program-related criminal offense.

The committee has included this provision in response to the concern that some program violators have been permitted continued participation, often without interruption, in Federal health care programs. The committee feels that misuse of Federal and State funds is a very serious offense and that those convicted of crimes against the programs should not be permitted continued and uninterrupted receipt of Federal and State funds. The committee believes that this threat of suspension, together with the upgraded penalties authorized under the bill, will serve as a significant deterrent to fraudulent practices under medicare and medicaid.

Under current law, physicians or other individual practitioners who have been convicted of an offense related to their participation in medicare or medicaid are not automatically suspended from these programs and can continue to receive payment therefrom. The Secretary may suspend Federal payment to a person who has falsified information related to a request for payment. The Secretary may also suspend a person who bills the program for charges substantially in excess of the person's customary charges or who has furnished services found to be substantially in excess of an individual's need, to be harmful, or to be of grossly inferior quality.

The bill requires the Secretary to suspend from participation under medicare, a physician or individual practitioner who he determines has been convicted of a criminal offense related to such individual's involvement in medicare or medicaid. To permit case-by-case determinations, the suspension would be for such period as the Secretary deems appropriate and no medicare payment could be made for any item or service furnished by such individual during this period. Individuals subject to suspension are those who are convicted on or after the date of enactment of the law or within such period prior to enactment as the Secretary may specify in regulation. Provision is made for appropriate notice to the individual and the public and hearing and judicial review of the Secretary's determination. In any case where the Secretary suspends a practitioner from participation in medicare he is required to promptly notify every State medicaid agency and the appropriate State or local licensing authority.

Whenever a State medicaid agency is notified by the Secretary that a practitioner has been suspended under medicare, it shall suspend such individual from participation in medicaid. This is intended to prevent practitioners from moving from one State to another in order to avoid the effect of the suspension. To conform the timing of suspensions, the medicaid suspension period shall not be less than the suspension period applicable to the individual under medicare. No medicaid program payments may be made for services provided by such individual during the suspension period.

In his notification to the licensing authority the Secretary shall request that investigations be made and sanctions be invoked, as deemed appropriate in accordance with the State's law and policy. The Secretary and Inspector General would be notified of whatever action, if any, is taken by these authorities.

The committee was concerned that imposition of this suspension, under certain unusual circumstances, could deny adequate access to medical care to persons eligible for services under medicare or medicaid. To ensure that this would not occur, the bill provides two remedies. First, the bill would authorize the Secretary to designate a community as a health manpower shortage area (as defined under title III of the Public Health Service Act) for purposes of placement of National Health Service Corps personnel, if he determines that imposition of a suspension would leave those residents of the area eligible under medicare or medicaid without adequate access to health services. Second, the bill permits the Secretary, on the request of a State, to waive a practitioner's suspension under the State's medicaid program. The committee intends that such waivers be granted sparingly. It is expected that waivers will only be approved where imposition of the suspension would deny a community of needed medical service because of the shortage of practitioners in that area and no National Health Service Corps personnel have been assigned.

The amendments made by this section would be effective upon enactment except for the provision relating to medicaid suspensions which would be effective for calendar quarters beginning on or after January 1, 1978.

Disclosure by Providers of Owners and Certain Other Individuals Convicted of Certain Offenses (Section 8)

The committee's bill requires all institutional providers of services participating in medicare, medicaid, or title XX State social service grant programs to disclose the names of owners and certain other individuals who have been previously convicted of fraud against any one of these programs. The bill also permits the Secretary or appropriate State agency to decline to enter into an agreement or contract with an institution whose application contains the names of any such individuals and further permits the Secretary or any State agency to terminate existing provider agreements if the names of such individuals have not been disclosed as required.

Current disclosure of ownership provisions do not require institutional providers of services and other agencies and organizations certified to provide services under titles XVIII and XIX of the Social Security Act to disclose information about criminal records any of their owners and managerial employees may have. Similar information is also not required from institutional providers participating in title XX of the Social Security Act, a number of whom are also certified to provide services under medicare and medicaid. Existing procedures for determining this information are inadequate, time-consuming, and have permitted individuals previously convicted of such offenses to continue ownership or management in participating facilities or become owners or managers in other participating facilities without program administrators being aware of an individual's past activities which might have a bearing on a facility's future performance.

Lack of adequate disclosure of these individuals is an additional restraint on HEW's attempts to investigate and control program abuse. It has hampered and restricted Department efforts to limit the participation of those facilities and other organizations providing services under titles XVIII, XIX, or XX that are partially owned or controlled by persons convicted of criminal offenses against the programs.

Even when such individuals can be identified by the Department of HEW or State administering agencies, it is difficult under existing procedures to limit participation of facilities owned by these persons. Currently, no provisions exist to enable the Secretary of HEW or a State agency to refuse to enter into or to terminate provider agreements or contracts with institutional providers or other organizations owned by such individuals as long as existing conditions for participation under titles XVIII, XIX, or XX are met.

The result of the failure of the current law to provide procedures whereby facilities owned by persons who have previously been convicted of fraud against medicare or medicaid has been that these persons continue to receive payments from the programs. Even criminal conviction is not sufficient to exclude an individual from the nursing home industry or the Medicaid system. Lengthy state administrative procedures must also be carried out, vulnerable to delaying litigation. The problem would be compounded under present law whenever a provider convicted in one State continues to operate in another. Then the speedy removal of the provider from the medicaid program would be almost impossible. Conferring the proposed powers on the Secretary would ensure that providers who have flagrantly abused the system will not be able to exploit the delays in State administration processes to continue their profiteering.

In order to deal with this problem, as a condition of participation, certification, or recertification under titles XVII, XIX, or XX of the Social Security Act, the bill would require all institutional providers of services, or other agencies, institutions, or organizations to disclose to the Department of Health, Education, and Welfare or to the appropriate State agency the names of its owners, officers, directors, agents, or managing employees who have been convicted of a criminal offense against medicare, medicaid, or State social service grant programs. The bill specifies that when an application requesting such participation or certification contains the names of any such previously convicted individual, the Secretary of HEW or the State agency may refuse to enter into an agreement or contract with the institution to provide services under titles XVIII, XIX, or XX. In addition, the bill specifies that the HEW Inspector General must be informed of any such applications received and of any actions taken on them. The bill would also permit the Secretary or appropriate State agency to terminate existing provider agreements or contracts under title XVIII, XIX, or XX, if the names of such individuals have not been disclosed, as required.

In applying the disclosure requirements to convicted persons who are officers, directors, agents, or managing employees of the institution, as well as to convicted persons with ownership interests, the committee feels that this parallel requirement is necessary in order to ensure that program administrators are aware of the renewed involvement of these persons in participating institutions.

The bill would specifically define the term "managerial employee" to mean a person who exercises operation or managerial control over the institution or one who directly or indirectly conducts the day-to-day operations of the institution including, but not limited to, an institution's general manager, business manager, administrator, and director. The bill would define the owner of an institution as any person who has a direct or indirect ownership or control interest of at least 5 percent in the institution.

The amendments made by this section should apply with respect to contracts, agreements, and arrangements entered into and approvals given pursuant to applications or requests made on and after the first day of the fourth month following enactment.

Federal Access to Records (Section 9)

Under present law, State plans under medicaid are required to provide for agreements with every person or institution providing services whereby such persons or entities will keep complete records of services provided under the program and furnish the State agency, upon request, which information regarding any payments claimed under the program. Similar access to records by the Secretary is not required. The committee feels this could hamper Federal efforts to obtain information necessary to examine potential instances of fraudulent and abusive activities. The bill therefore specifically permits the Secretary to have access to records of persons or institutions providing services under medicaid in the same manner presently provided to State medicaid agencies.

The amendment made by this section would be effective upon enactment.

Claims Processing and Information Retrieval Systems for Medicaid Programs (Section 10)

The bill permits States to send explanation of benefits forms to a sample of medicaid recipients and still be entitled to increased Federal matching for operation of approval management information systems. The bill specifies that there would be no explanation of benefit forms in the case of services which are confidential in nature.

Present law authorizes an increase in Federal matching to 75 percent toward the costs of operating an approved medicaid claims processing and information retrieval system if the system provides explanation of benefits information to all recipients. The committee has been informed that this strict requirement for explanation of benefit forms in every case has limited the growth of approved systems. In addition, questions have been raised about the cost effectiveness of this requirement because of the high volume of claims for services provided under medicaid.

The bill therefore modifies the current requirement by permitting the increased matching if the system provides explanation of benefits information to a sample group of recipients. The committee expects that the samples will be of sufficient size and sufficiently representative of the population served and the services rendered to enable the identification of any questionable or unusual patterns. It is the intention of the committee that all confidential services, and services integrally related to a confidential service such as family planning services and venereal disease treatment be deleted from the explanation of benefit forms in order to assure privacy for the medicaid patient. States will be expected to institute appropriate safeguards to accomplish this.

The committee notes that this change in the medicaid statute does not constitute a new entitlement to higher Federal matching, but merely increases the workability of the existing provision.

The amendment made by this section would apply with respect to calendar quarters beginning after the date of enactment.

Restriction on Federal Medicaid Payments. Assignment of Rights of Payment; Incentive Payments (Section 11)

The bill precludes Federal matching payments for expenditures under medicaid for services which a private insurer would have an obligation to pay except for a provision of its insurance contract which has the effect of limiting or excluding such obligation because the individual is eligible for or receiving medicaid.

The section also establishes a medical support program under which medicaid applicants and recipients may be required by a State to assign their rights to medical support or indemnification to the State. Incentives would be provided for localities to make collections for States and for States to secure collections in behalf of other States.

Under current law, States or local agencies administering medical assistance plans are required to take all reasonable measures to ensure that third parties legally liable to pay for any medical care rendered to medicaid recipients meet their legal obligations. However, some private insurance policies contain a provision that limits the insurance companies' liability to the amount not covered by medicaid. In some cases, State insurance commissioners have not taken action to stop this practice. When it occurs, the medicaid program is forced to assume the costs despite the existing subrogation requirement.

The bill would provide an incentive to States to stop this practice by stopping all Federal matching payments for expenditures made under the plan for care or services provided to the extent the private insurer (as defined by the Secretary) would have been obligated to pay except for a provision of its contract which has the effect of limiting or excluding such obligation because the individual is receiving assistance under medicaid.

States have advised the committee that there are cases where absent parents who have been ordered by a court to provide for the medical support of their families have failed to do so. Frequently these families must turn to the medicaid program for their medical needs. The medical support program established by the bill would authorize States to require that medicaid recipients and applicants, as a condition of eligibility, assign their medical support or indemnification rights to the State. The State would enter into cooperative arrangements to secure the medical support. Localities securing collections on behalf of the State and States securing collections on behalf of other States would receive incentive payments of 15 percent of the amounts collected.

The amendments made by this section would apply with respect to medical assistance provided and assignments made for calendar quarters beginning on or after January 1, 1978.

Study and Review of Medicare Claims Processing (Section 12)

The committee bill directs the Comptroller General to conduct a comprehensive study of the claims processing system under medicare for the purpose of determining what modifications should be made to achieve more efficient claims administration.

Under medicare part A, groups or associations of providers can nominate an organization to serve as a fiscal intermediary between the providers and the government. An individual member of an association or group of providers that has nominated one organization as intermediary may select some other organization if this is satisfactory to the organization and HEW, or alternatively it may elect to deal directly with the government. HEW may not enter into an agreement with an organization unless it finds that such agreement is consistent with efficient and effective administration. The Social Security Administration selected 10 hospital-nominated organizations to serve as intermediaries. These include the Blue Cross Association which carries out its claims administration activities through 73 statewide and local Blue Cross plans. Under medicare part B, the Secretary contracts with carriers to perform claims processing activities. Carriers are selected to serve specified geographic areas. There are 47 carriers, including 32 Blue Shield plans. Both intermediaries and carriers are reimbursed on a cost basis for carrying out their activities.

A reexamination of the administrative framework of the medicare program in order to assess the need for possible modifications is desirable.

The committee bill therefore directs the Comptroller General to conduct a comprehensive study and review of the administrative structure established for processing claims under medicare. The study is to determine whether and to what extent more efficient claims administration could be achieved by reducing the number of carriers and intermediaries, making a single organization responsible for processing claims under parts A and B in a particular geographic area, paying for claims processing on the basis of a prospective fixed price, providing other types of incentive payments for efficiency, or by other modifications in existing structure and procedures. The Comptroller General would be required to submit a report containing his findings and recommendations to the Congress by July 1, 1979.

The amendment made by this section would be effective upon enactment.

Abolition of Program Review Teams Under Medicare (Section 13)

The committee bill repeals the provisions in current law relating to program review teams.

The Social Security Amendments of 1972 included a provision authorizing the Secretary to suspend or terminate medicare payments to a supplier of services found to have abused the program. In the case of such a suspension or termination, Federal participation was also to be withheld for medicaid payments made in behalf of such supplier. This provision was included to permit HEW to bar future payments to suppliers who have made a practice of furnishing inferior or harmful supplies or services, engaging in fraudulent activities, or consistently overcharging for their services.

To assist him in making determinations under this section, the Secretary was required to establish program review teams in each State. These professionally based bodies were to advise the Secretary concerning such matters as whether excessive, harmful, or grossly inferior care is being rendered to patients. The functions of program review teams relating to the review of the quality and appropriateness of services are essentially duplicative of the functions required to be performed by PSRO's.

The committee bill therefore deletes the requirements in current law pertaining to the establishment and responsibilities of program review teams with the expectation that the appropriate PSRO will instead be available to advise the Secretary in cases that require the application of professional medical judgment.

The amendment made by this section would be effective upon enactment.

Nomination of Intermediaries by Providers (Section 14)

The bill would prohibit the Secretary from refusing to enter into an agreement with a nominated intermediary solely because of the fact that such intermediary does not operate regionally or nationally.

Under present law, the Secretary of HEW is authorized to use public agencies or private organizations to facilitate medicare payment to providers of services. Such agencies or organizations (intermediaries) are ordinarily nominated by the individual provider. For example, most hospitals have nominated Blue Cross Association as their intermediary and the Secretary has contracted with that organization. The Blue Cross Association, in turn, utilizes local Blue Cross plans for the day-to-day administrative and operating activities.

The Secretary is prohibited from entering into an agreement with any agency or organization unless he finds that to do so is consistent with effective and efficient administration; that the intermediary is willing and able to assist providers in safeguarding against unnecessary utilization of services; and that the intermediary agrees to provide the Secretary with such information as it may acquire in performing its duties and which he finds necessary in performing his functions.

The committee is concerned that the Secretary may refuse to enter into an agreement with a prospective intermediary nominated by a provider or group of providers, or may terminate an agreement with an existing intermediary, solely on account of the fact that the intermediary transacts business only within the State in which the provider(s) is located and that current law indirectly may give him the authority to require the designation instead, of a regional or national intermediary.

The committee has, therefore, included an amendment prohibiting the Secretary from refusing to enter into an agreement with a nominated intermediary, terminating an existing agreement, or making a determination with respect to whether an agreement or proposed agreement is effective or efficient, solely because of the fact that such intermediary operates only within a single State or on the basis that regional or national intermediaries serve or could serve providers within the State. It is the intention of the committee that the Secretary not go outside the State to a region or beyond when providers within a a given State wish to be served (and other applicable requirements of the statute are met) by intermediaries who operate wholly within the State.

Disclosure by Providers of the Hiring of Certain Former Employees of Fiscal Intermediaries (Section 15)

The committee bill would require a provider of services under the medicare program to notify the Secretary promptly of its employment of an individual who at any time during the preceding year was employed in a managerial, accounting, auditing or similar capacity by a fiscal intermediary or carrier who had served that provider.

In certain cases in the past, providers have specifically recruited and employed personnel of the fiscal intermediary serving it, apparently in order to assist the provider in justifying questionable accounting and cost reporting procedures. This type of hiring practice potentially subverts the integrity of the intermediary provider relationship, including the integrity of the auditing process. The Department of HEW is expected to utilize the information gained under the notification required under the bill to discourage such practices, especially when such information suggests possible conflict of interest situations.

Providers who hire employees of fiscal intermediaries, particularly accountants and auditors who have been involved in auditing that provider, should be on notice that such practices will be followed closely.

The amendment made by this section would apply with respect to agreements entered into or renewed on and after the date of enactment.

Payment for Durable Medical Equipment (Section 16)

The committee bill would modify the present methods for reimbursing medicare beneficiaries for expenses incurred in obtaining durable medical equipment. The intent of this modification is to reduce program expenditures and assure greater protection for beneficiaries against the need to pay excessive rental fees.

Present law provides for reimbursement under part B of medicare for expenses incurred in the rental or purchase of durable medical equipment used in the patients' home. The beneficiary has the option to rent or purchase such equipment. In the case of purchase, reimbursement is generally made in monthly installments equivalent to amounts that would have been paid had the equipment been rented.

Reimbursement may be made on a lump-sum basis for purchased equipment that is relatively inexpensive, i.e., items for which the reasonable charge is $50 or less.

Where a beneficiary elects to rent equipment, medicare will continue to reimburse him for 80 percent of his rental expenses as long as his medical need for the equipment continues. A study conducted by GAO showed that rental payments under the program for durable medical equipment require over an extended period of time frequently exceeded, by a substantial amount, the reasonable purchase price of the equipment. Moreover, beneficiaries were also overpaying for equipment since they are liable for the 20-percent coinsurance amount.

The Social Security Amendments of 1972 added provisions to the law to help avoid unreasonable expenses to the program and to beneficiaries resulting from prolonged rentals of equipment. These provisions authorized the Secretary to experiment with alternative reimbursement mechanisms, including the use of lease-purchase arrangements and lump-sum payments for purchased equipment where it could be determined in advance that the use of the equipment would be medically necessary for an extended period of time. Although the Department has not conducted the extensive experimentation contemplated by the legislation, sufficient evidence is available to indicate that changes in the reimbursement methods are needed to deal with the long-standing problems arising under the durable medical equipment provision of law.

To remedy these problems, the committee bill makes several changes in the methods used in reimbursing beneficiaries and suppliers for durable medical equipment. First, the bill requires the Secretary to determine, on the basis of medical evidence, whether the expected duration of medical need for the equipment warrants the presumption that purchase would be less costly or more practical than rental, and would not impose financial hardship on the beneficiary. Where such a presumption can be made, the Secretary would require purchase of the equipment and would provide reimbursement on the basis of a lump-sum payment or on the basis of a lease-purchase arrangement. Since lease-purchase would generally be the preferred mode of payment, and would ordinarily provide the greatest degree of cost-effectiveness for the program and the beneficiary alike, the bill specifically directs the Secretary to take steps to encourage suppliers, through whatever administrative arrangements he finds feasible and economical, to make equipment available to beneficiaries on a lease-purchase basis.

Second, the bill retains the provision in existing law which authorizes the Secretary to waive the 20-percent coinsurance requirement with respect to the purchase of used durable medical equipment whenever the purchase price is at least 25 percent less than the reasonable charge for comparable new equipment.

The amendment made by this section would apply to durable medical equipment purchase for rented on or after October 1, 1977.

Funding of State Medicaid Fraud Control Units (Section 17)

The committee bill authorizes 100 percent Federal matching in fiscal year 1978, 90 percent matching in fiscal year 1979, and 75 percent matching in fiscal year 1980 for the establishment and operation of State medicaid fraud control units. The bill also authorizes the

Secretary to conduct demonstration projects for the purpose of developing improved methods for the investigation and prosecution of fraud in the provision of health services under the Social Security Act.

The committee is concerned that sufficient efforts have not been made to date to identify and prosecute cases of medicaid fraud in a number of States. In the absence of effective investigative units, individuals engaging in fraudulent practices are able to continue their activities virtually unchecked. Sections of the bill provide for criminal sanctions and suspension actions for those convicted of medicaid fraud. However, strengthened penalties must be coupled with strengthened investigatory powers in order to assure that those engaging in criminal activities are identified and prosecuted. Further, the combination of rigorous enforcement and criminal sanctions should serve as a deterrent to similar practices by other providers and practitioners.

Testimony has been presented to the Congress showing that where a separate statewide investigative entity has been established, the rate of prosecutions and convictions has been substantially increased. For example, there was testimony that in the period from 1970 to January 1975, there was not a single prosecution in New York State for medicaid fraud arising out of the operation of a nursing home. In January 1975, a special office was established to examine the rapidly growing scandal in the nursing home industry. As a result of its investigations, grand juries have indicted more than 90 individuals mostly for medicaid fraud. To date, there have been 27 convictions and the office has forced payment of more than $4 million in criminal restitution—an amount several hundred thousand dollars in excess of the offices first year budget. The committee is particularly impressed with the organization and operation of the New York Special Prosecutor's Office and its demonstrated effectiveness, and believes it constitutes a model for antifraud efforts in other States.

The committee has learned that a number of States are interested in establishing or strengthening existing medicaid fraud and abuse control units. it wished to encourage efforts similar to the New York unit. However, in view of the fiscal constraints being experienced by many of them, the current 50-percent administrative matching rate has not served as a sufficient incentive to the establishment or expansion of such units. The committee believes that a short-term increase in the Federal matching rate will enable States to establish effective investigative entities and expand existing efforts. After these units have been operational for a few years, their recoveries from prosecutions should begin to equal or exceed the cost of operation. Therefore, under the bill, the increased matching rate would only be in effect for 3 years.

The committee bill therefore provides for 100 percent Federal matching in fiscal year 1978, 90 percent in fiscal year 1979, and 75 percent in fiscal year 1980 for the costs incurred in the establishment and operation (including the training of personnel) of State fraud control units meeting specified requirements, subject to a quarterly limitation of the higher of $125,000 or one-quarter of 1 percent of total medicaid expenditures in such State in the previous quarter.

To be eligible for the increased matching rate, the State medicaid fraud control unit must be a single identifiable entity of State government which the Secretary certifies (and annually recertifies) as meeting specific requirements. Such entity must be a unit of the office of the State Attorney General or of another department of State government which has statewide prosecutorial authority (unless it is located in a State where the State constitution prohibits prosecution by a statewide authority, or an entity which is independent of the single State agency or medicaid agency—if different—and has a close working relationship with the State attorney general's office; then, to receive the higher matching, the unit must have procedures acceptable to the Secretary of HEW to refer suspected criminal violations to the appropriate prosecuting authorities, and to assist with the prosecutions. Any entity would be required to be separate and distinct from the State medicaid agency (or single State agency). If the unit is not part of the State attorney general's office, it must have a close working relationship with that office or other appropriate prosecuting authorities in the State. Such relationship should include procedures for referral of suspected criminal violations and assistance with prosecutions.

The State fraud control unit must conduct a statewide program for the investigation and prosecution of violations of all applicable State laws relating to fraud in connection with the provision of medical assistance and the activities of medicaid providers. Such unit is not, however, required to examine potential instances of recipient fraud; this function may continue to be the responsibility of the State medicaid agency. The fraud and abuse control unit must have procedures for reviewing complaints of the abuse and neglect of patients by health care facilities, and, where appropriate for acting on such complaints or for referring them to other State agencies for action. The entity is required to provide for the collection, or referral for collection, of overpayments made to health care facilities. In order to promote effective and efficient conduct of the entity's activities, it must be organized in a manner to achieve these objectives and it must employ auditors, attorneys, and investigators and other necessary personnel. The entity is further required to submit an application and annual report containing information deemed necessary by the Secretary to determine whether the entity meets these requirements. To facilitate implementation of this section, the Secretary is required to issue regulations within 90 days of enactment.

The committee wishes to emphasize the need for the employment of highly skilled auditors, attorneys, and investigators specially trained in the area of medicaid fraud. The committee has received substantial evidence of the complex schemes employed by those engaging in fraudulent activities and notes that the only way such practices can be effectively addressed is by utilizing persons specially skilled in uncovering these activities.

The committee intends that the increased matching rate authorized under this section be made available to existing State fraud control units providing they meet (or appropriately modify their operation so as to meet) the specified requirements.

The bill specifically authorizes the Secretary (in addition to his general authority to carry out demonstrations designed to improve administration and effectiveness of Social Security Act programs) to arrange for demonstration projects designed to develop improved programs for the detection, investigation, and prosecution of fraud and abuse.

The committee has been impressed by the innovative methods employed by several States in the detection, investigation and prosecution of certain types of fraudulent and abusive activities under the medicare and medicaid programs. The committee believes that States, such as New York, which have demonstrated their ability to conduct vigorous and innovative antifraud activities with respect to one class of providers should be encouraged to develop and implement such programs with respect to other classes of providers.

The amendment authorizing increased Federal matching payments would apply with respect to calendar quarters beginning after September 30, 1977. The amendment authorizing demonstration projects would be effective on enactment.

Report on Home Health and Other In-Home Services (Section 18)

The committee's bill would require the Secretary of Health, Education, and Welfare to report to Congress on home health and other in-home services authorized under titles XVIII, XIX, and XX of the Social Security Act.

The committee is concerned that, with respect to home health and in-home services authorized to be provided under medicare, medicaid, and title XX social service programs, more effective methods need to be developed to assure the quality of services provided and efficiency in administration of the programs, and more effective efforts to curb fraud and abuse. While it is understood that there are, by necessity, differences among these programs in entitlement to the services and the types of services covered, it is the feeling of the committee that any efforts to develop methods of quality assurance and administrative efficiency should, where possible and practical, provide for coordination between the programs, particularly with respect to requirements for providers of services and reimbursement methods.

The Secretary is, therefore, directed to submit within 1 year a report to the appropriate committees in Congress analyzing all aspects of the delivery of home health and in-home services authorized under these titles. Further, since the intent of this legislation is to facilitate establishment of a set of specific, enforceable standards in the programs to assure high quality home health services and the protection of the health and safety of recipients of such services, the Secretary is required to report on regulatory changes needed and to recommend appropriate statutory changes with respect to quality assurance and administrative efficiency.

The committee has not addressed the question of inclusion of proprietary home health agencies beyond the provisions of current law. However, the committee would note that the standards for quality review to be developed should be suitable for application to all home health providers, regardless of sponsorship.

The Secretary of Health, Education, and Welfare has been designated to conduct this study in view of the extensive information gathered by the Department during recent regional hearings on home health care and the subsequent activity of the Department in analyzing this information. The Secretary is to include in this report an analysis of the impact of his recommendations on the demand for and cost of services authorized under the programs and the method of financing any recommended increase in the provision of such services.

The amendment made by this section would require the submission of the report within 1 year of enactment.

Uniform Reporting Systems for Health Services Facilities and Organizations (Section 19)

The bill would require the Secretary to establish for each of the different types of health services facilities and organizations a uniform system for the reporting of such items as cost of operation, volume of services, rates, capital assets and bill data. This reporting system would be mandated for use by medicare and medicaid providers and such use would be phased in by type of provider.

A persistent problem under the medicare and medicaid programs as currently structured is the presence of variations in the information contained in medicare and medicaid cost reports. Since it is generally agreed that the existence of comparable cost and related data is essential for effective cost and policy analysis, the assessment of alternative reimbursement mechanisms and, in certain situations, the identification and control of fraud and abuse, the committee believes it is necessary to correct the deficiencies in the present reporting system under these programs.

Accordingly, the bill requires the Secretary to establish for each type of health service facility or organization a uniform system for the reporting of the following types of information:

(1) The aggregate cost of operation and the aggregate volume of services;

(2) The costs and volume of services for various functional accounts and subaccounts;

(3) Rates, by category of patient and class of purchaser;

(4) Capital assets, as defined by the Secretary, including (as appropriate) capital funds, debt service, lease agreements used in lieu of capital funds, and the value of land, facilities, and equipment; and

(5) Discharge and bill data.

It is the committee's intent that the uniform reporting system for each type of health service facility or organization provide for appropriate variation in the application of the system to different classes of facilities or organizations within that type. The Secretary would be required to develop and establish uniform reporting systems, after consultation with interested parties, for hospitals, skilled nursing facilities and intermediate care facilities within a year following enactment of this legislation, and for other types of health service facilities and organizations (such as home health agencies) within 2 years of enactment.

The committee intends that in the development and implementation of uniform reporting requirements the Secretary shall take into account the administrative costs both for the institutions and the Department as well as the relationship of those costs to enhanced program administration.

Within each class of facility, cost allocation formats and definitions should be uniform. Each institution of a particular type performing a function to which a standard applies should be required to report on such functions in the same way. For example, all hospitals should be required to report X-ray costs on the basis of costs per patient exposure to diagnostic X-ray. Another type of institution, such as a long term care facility, may be required to employ another method, if one more suited to such type of institution's operations can be formulated. This combination of variation by institutional type and uniformity within each such type of institution provides necessary flexibility while assuring that the information obtained is useful.

It is also the committee's intent that the Secretary should take into account the unique organizational arrangement of health maintenance organizations, and should make those adjustments he finds necessary and appropriate to tailor the uniform reporting system to their particular situation, while maintaining the necessary comparability of data.

Under the bill, the Secretary would require all medicare and medicaid providers of services to submit reports to the Secretary of the aforementioned cost-related information in accordance with the uniform reporting system. For hospitals, skilled nursing facilities, and intermediate care facilities, these uniform reports would be required beginning with their first fiscal year that begins more than 6 months after the reporting system has been promulgated by the Secretary. For all types of health service facilities or organizations, the reporting requirement will only be implemented at such time (after such systems are promulgated for these institutions) as the Secretary deems to be most productive. After establishing the uniform systems of reporting, the bill requires the Secretary to monitor their operation, assist with support demonstrations and evaluations of the effectiveness and cost of the operation of such systems, encourage State adoption of such systems and periodically revise the systems to improve their effectiveness and diminish their cost.

Under the bill, the Secretary would be required to provide such information obtained through use of the uniform reporting system as may be deemed necessary by him to assist health systems agencies and State health planning and development agencies in carrying out such agencies' functions.

The Secretary would prescribe a chart of accounts to be used by hospitals to help to achieve the needed uniformity of reporting. The chart of accounts would be designed for this limited purpose so that its application should not prove unduly onerous.

Modification of Requirements for State Medicaid Utilization Control Programs (Section 20)

The committee bill modifies the requirements of current medicaid law concerning review of care delivered in institutional facilities. The section waives application of the penalties for noncompliance for calendar quarters ending prior to January 1, 1978. For subsequent

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calendar quarters, the required reductions in Federal matching would be imposed only in proportion to the number of patients whose care was not reviewed compared to the total patient population subject to review.

The section further specifies procedural requirements for the Secretary to carry out the validation requirements under Section 1903(g)(2) in more timely fashion.

The bill also modifies the requirements pertaining to the composition of medical review teams in skilled nursing facilities so as to conform them with those requirements applicable to intermediate care facility review.

The "Social Security Amendments of 1972" (Public Law 92-603) added section 1903(g) to the Social Security Act. This section requires a one-third reduction in Federal matching payments under medicaid for long-term stays in institutional settings, unless a State demonstrates that it has an adequate program of control over the utilization of institutional services. The program must include a showing that:

(1) The physician certifies at the time of admission and recertifies every 60 days that the patient requires inpatient institutional services.

(2) The services are furnished under a plan established and periodically reviewed by a physician.

(3) The State has a continuous program of utilization review whereby the necessity for admission and continued stay of patients is reviewed by personnel not directly responsible for care of the patient, not financially interested in a similar institution, or, except in the case of a hospital, employed in the institution.

(4) The State has a program of independent medical review for SNF's, ICF's, and mental hospitals whereby the professional management of each case is subject to independent annual review. The section further requires the Secretary to conduct sample onsite surveys of institutions as part of his validation procedures.

The committee notes that this section was to go into effect on July 1, 1973, as an incentive payment for States showing a satisfactory program of utilization control. States which did not make the requisite showings were automatically to be subject to the reduced Federal matching rate. Despite the clear intent of the law and extensive evidence developed by the Congress and the Comptroller General of the United States, that a large number of States failed to meet the requirements, HEW indicated that it was reluctant to impose the reductions. The first reduction actually to be imposed under this authority was announced to take effect July 1977. During the intervening 4-year period the committee has on a number of occasions indicated its concern that HEW had failed to fulfill its responsibilities.

On June 8, 1977, HEW announced that it would reduce July 1977 medicaid payments to 20 States by a total of $142 million (actual application of these announced reductions was delayed by Public Law 95-59 until October 1977). These reductions were to take effect because the States failed, during the first quarter of 1977, to conduct annual medical reviews of patients in long-term care facilities. The Department further announced that it had under review the potential disallowance of $378 million of fiscal year 1975 funds for failure to have adequate utilization controls in place, based upon validation requirements. The committee is encouraged that the Department has begun to aggressively implement the congressional mandate. However, in view of past inaction on the part of HEW, it feels that the sudden reduction in Federal funds for past years activities could have a severe and unanticipated impact on affected State medicaid programs. Further, Congress intended this program to be an incentives program to be validated on a current basis by HEW. This section is intended to bring this validation process into timely synchronization with State showings.

The committee bill waives application of reductions in matching for noncompliance for calendar quarters ending prior to January 1, 1978. For subsequent calendar quarters, the required reductions in Federal matching would be imposed only in proportion to the number of patients whose care was not reviewed compared to the total patient population subject to review. This provision is included because, among other reasons, HEW had in June 1977 announced penalties on States which failed to review only two or three homes out of hundreds of homes subject to review within the annual time limit.

The committee believes that imposition of the full reduction in such cases would be unduly severe. The bill therefore modifies the existing language to assure that the reduction will be assessed in proportion to the population whose care was not subject to the required review.

The committee bill also authorizes the Secretary to waive a reduction otherwise required by law to be imposed if the State's noncompliance is technical or due to circumstances beyond its control. The committee intends, however, that this waiver authority is to be invoked only when reasonably appropriate and not as a generalized routine exception. Circumstances considered outside of a State's control are those which could not reasonably be anticipated and provided for in advance. Technical noncompliance for example, would include instances where a State had reviewed patients in most facilities on time with the remaining facilities also reviewed but not until several weeks after the deadline for completion of all reviews by a State.

The committee bill provides that a State should provide its required showing of compliance with review requirements with respect to a calendar quarter to HEW within 30 days of the end of the quarter, so that HEW can make the appropriate determinations and give States sufficient notice of any action (although HEW can extend the period if the Secretary finds good cause for doing so). The committee intends that the required showing will demonstrate good faith efforts on the part of a State to conduct on-site reviews of these patients subject to review in hospitals, skilled nursing facilities, and intermediate care facilities. The bill also modifies the requirements for the composition of medical review teams in skilled nursing facilities to permit them to be headed by either a physician or registered nurse.

While existing law requires the Secretary to undertake onsite validation surveys in timely fashion, HEW has not done so in the past. When they have performed validations, the validations have lagged months and even years behind the year in question. The committee believes HEW has an obligation to the States, to the Congress, and to institutional care recipients to undertake validations in a timely

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fashion, and to impose any reductions resulting from them at that point. States should not be subjected to the uncertainty of a possible reduction years later. Accordingly, the bill requires that the Secretary must complete his validations and give notice of his determinations within 9 months of the end of the period in question if he is imposing reductions on the States as a result.

The section also requires the Secretary to submit to the Congress within 60 days of the close of each calendar quarter a report on: (1) his determination as to whether showings made by States are satisfactory; (2) his review of the validity of previously submitted showings; and (3) any reductions made for the quarter.

The amendment would be effective with respect to calendar quarters beginning on and after October 1, 1977.

Protection of Patient Funds (Section 21)

The committee bill requires that as a condition for participation in the medicaid and medicare programs, a skilled nursing or intermediate care facility must establish and maintain a system to assure the proper accounting of personal patient funds.

Nursing home patients normally turn their personal funds over to the facility to hold and manage until they need them for their personal use. The General Accounting Office, the Senate Committee on Aging, and State investigators have found that misuse of these personal funds exists in some nursing homes. The types of abuse cited include: Charging patients' personal funds for items which should have been provided as part of routine medical care, improper maintenance of records of receipts and disbursements of patients' funds, use of funds to meet operating costs, commingling of patients' funds with operating funds, use of patients' funds as collateral for a loan for operating expenses, and retaining for the home interest earned on patients' funds.

The bill would therefore require that, as a condition for participation in the medicare and medicaid programs, a skilled nursing or intermediate care facility must establish and maintain a system to assure the proper accounting of personal patient funds. Such system must provide for separate and discrete accounting for each patient with a complete accounting of income and expenditures so as to preclude the intermingling of other funds with patient funds. The Secretary would be required to issue regulations within 90 days of enactment defining what types of items are to be paid from patients' personal funds.

The amendment would be effective on the first day of the first calendar quarter which begins more than 6 months after the date of enactment.

Provision for Flexible Grace Period (Section 22)

The committee bill modifies present law provisions pertaining to payment for institutional services after a PSRO has determined that such services are no longer required.

Under present law hospital and skilled nursing facility patients who are determined to need no further care in the institution are allowed an additional 3 days of benefits to give them time to arrange for their postdischarge care. It has come to the committee's attention that the mandated 3-day grace period has sometimes undermined the effectiveness of the PSRO review effort by unnecessarily delaying discharges. Therefore, the committee's bill would reduce the 3-day period to 1-day where a PSRO is undertaking the review, and permit the PSRO to authorize up to 2 additional days on a case-by-case exception basis where the facts in the case indicate that the additional time is needed to arrange for the necessary postdischarge care.

The amendment would be effective upon enactment.

Prosecution of Civil Fraud by Inspector General (Section 23)

The committee bill authorizes prosecution of civil fraud cases under the Social Security Act health care programs by the Inspector-General of HEW where U.S. attorneys have not initiated proceedings within 6 months of formal referral of a case.

The committee believes that strengthened program penalties provided for under the bill coupled with more intensive anti-fraud efforts by both HEW and the Department of Justice should facilitate timely prosecution of criminal violations. The committee is concerned, however, that similar intensive efforts must be made to prosecute cases of civil fraud. Testimony received by the committee indicates that there is some hesitation in pursuing prosecution of these cases as expeditiously as criminal cases. In 1976, Congress created the Office of the Inspector General in the Department of Health, Education, and Welfare. The Inspector General was required to establish within his office a unit with specific responsibility for antifraud and antiabuse activities relating to health care financing programs. The Inspector General was not, however, empowered to prosecute. The committee bill would authorize the Inspector General to prosecute, under certain circumstances, civil fraud cases relating to health programs authorized under the Social Security Act in order to facilitate the timely disposition of these cases. Specifically, the Inspector General would be permitted to prosecute such cases if the Justice Department has not initiated formal legal action within 6 months of a formal referral to it by HEW of an alleged fraud case.

This authority to prosecute is residual. It is intended, primarily, to deal with those situations where appropriate fraud prosecutions are not undertaken because of workload considerations or lack of expertise.

The amendment would be effective upon enactment.

Utilization Review Demonstration Projects (Section 24)

The bill authorizes the establishment of demonstration projects in States which currently have a medicaid hospital onsite evaluation system for the purpose of evaluating the effectiveness of PSRO reviews compared to alternative State review methods.

During consideration of the bill, questions were raised concerning the comparative impact of PSRO review versus that of existing State onsite hospital review systems. Accordingly, the committee bill authorizes the Secretary to provide for the establishment of demonstration projects in States which had operating onsite State evaluation systems in place on August 5, 1977, and which make application to the Secretary prior to May 1, 1978. The purpose of the projects will be to evaluate the effectiveness, both in terms of the quality and appropriateness of medical care as well as the impact on State budgets, of PSRO hospital review compared to alternative State hospital review systems. Demonstration projects shall be conducted in PSRO areas which are representative of a State's medicaid population and comprise a significant proportion of medicaid patient days. Services provided to medicare patients in project areas will be subject to PSRO review.

The committee bill requires the Secretary to select an independent organization to establish the study design of the demonstration project as well as to monitor, evaluate, and report on the study's findings. The study design shall provide that each hospital in a project area shall be designated as subject to either PSRO review or alternative State review. To the extent feasible, the selection of facilities shall insure a comparability of institutions and patients in each category. Approximately half of the medicaid patient load in each demonstration area (but in different hospitals) shall be subject to PSRO review while half shall be subject to the alternative State review system. The independent organization is required to maintain an ongoing monitoring role and to evaluate the effectiveness of each review system. Criteria used for evaluation shall include but not be limited to quality, appropriateness and availability of patient care, as well as changes in total patient days, numbers and types of services provided, and operating costs. The study design shall further insure that any changes in the number of providers, availability of beds, or other factors that could affect the statistical validity of the project shall be taken into account.

The committee bill provides that an approved demonstration project shall ordinarily run for 2 years following acceptance of the study design by the Secretary. The committee expects that any demonstration projects conducted under this authority shall run concurrently. The bill requires the Secretary to submit to the Senate Committee on Finance and the House Committees on Ways and Means and Interstate and Foreign Commerce an interim report at the end of the first full year of operation. The Secretary is required to submit a final report to these committees within 3 months of the completion of the demonstration projects. The reports shall contain the findings of the independent organization selected to monitor the project together with the Secretary's comments and recommendations. The committee bill provides that review costs in demonstration areas shall be funded as provided for under current law. Approved PSRO review costs will be fully federally funded while review costs of State review programs will be matched at the rate applicable for administrative costs under State medicaid programs. Both State review and PSRO decisions shall be considered conclusive for purposes of payment for the group of hospitals they are responsible for reviewing as part of the demonstration project. The Secretary may, however, suspend for good cause either the State's or PSRO's conclusive determination authority. The committee bill further requires that PSRO areas in a State participating in a demonstration project but which themselves are not part of the project shall proceed to implement PSRO review requirements in a timely fashion. The committee expects that in such areas, good-faith efforts will be made to encourage the development and operation of PSRO review systems.

Payment for Certain Hospital Services Provided in Veterans' Administration Hospitals (Section 25)

The bill would authorize, under certain circumstances, reimbursement to a Veterans' Administration hospital for care provided to a nonveteran medicare beneficiary.

Under current law, medicare payments cannot be made to a Federal provider of services. The committee has learned of a limited number of cases where care was provided in a VA hospital on the assumption that the medicare beneficiary was also an eligible veteran. However, such individual was subsequently determined not to be entitled to care in the VA hospital and was forced to assume the costs of the care provided.

The committee bill amends current law to permit reimbursement to a Veterans' Administration hospital for care provided to a medicare beneficiary under certain limited circumstances. Specifically, the individual must not have been entitled to have services furnished free of charge by a VA hospital but upon admission there must have been the reasonable belief on the part of the admitting authorities that he was entitled to have such services furnished to him. Further both the admitting authorities and the individual must have acted in good faith. The VA hospital must have discontinued furnishing such services on the day the authorities first become aware that the individual was not entitled to have services furnished free of charge, or, if later, on the first day it was medically feasible to discharge him or transfer him to a hospital participating under medicare.

The bill provides that payment for hospital services furnished to a nonveteran medicare beneficiary shall be equal to the charge imposed by the VA for such services or, if less, the reasonable cost of such services. Payment shall be made to the entity to which the payment would have been payable if the payment had been made by the individual receiving the services or by another acting on his behalf.

The amendment made by this section would be applicable in the case of inpatient hospital services furnished on and after July 1, 1974.

Hospital Insurance for Individuals, Age 60 Through 64, Who Are Entitled to Benefits Under Section 202 or Who are Spouses of Individuals Entitled to Health Insurance (Section 26)

The bill would permit certain persons aged 60–64 to buy into madicare at a premium rate equal to the cost of their protection.

The committee is concerned that many social security and railroad retirement cash beneficiaries aged 60–64 and spouses aged 60–64 of medicare beneficiaries find it difficult to obtain adequate private health insurance at a rate which they can afford. Frequently these older persons—retired workers, wives, husbands, widows, widowers, mothers, parents, brothers and sisters, for example—have been dependent for health insurance protection on their own group coverage or that of a related worker who is now retired or deceased. It is a difficult task for such older persons to secure comparable protection at affordable cost when they are not connected with the labor force.

The bill therefore includes a provision which would make medicare protection (both part A and part B) available on an optional basis at cost to spouses aged 60–64 of medicare beneficiaries; others aged 60–64 who are entitled to retirement, wife's, husband's, widow's, widower's, mother's, or parent's, under social security and the railroad retirement programs; and disability beneficiaries aged 60–64 not otherwise eligible for medicare because they have not been entitled to cash disability benefits for 24 months, the availability of medicare protection would be limited to persons aged 60–64 because the committee believes that people under age 60 who are not disabled generally have relatively little difficulty in obtaining private health insurance.

Persons who elect to avail themselves of medicare protection under this provision would pay the full cost of such protection. Enrollees would pay a monthly part A premium based upon the estimated cost of hospital insurance protection for persons eligible to enroll plus amounts sufficient to cover administrative expenses and underwriting losses or gains, if any; such premium would be equal to the premium charged to others eligible to enroll under part A until July 1, 1979, and would be adjusted for each 12-month period thereafter to reflect both the experience of the group and any changes in costs.

The monthly premium for persons in the group who enroll for part B would be three times the premium paid by an individual who has attained age 65 until July 1979 and would be adjusted for each 12-month period thereafter to reflect the estimated cost of supplementary medical insurance protection for persons eligible to enroll under the provisions plus amounts sufficient to cover administrative expenses and underwriting losses or gains, if any. Aliens who have been in the United States less than 5 years and persons who have been convicted of certain subversive crimes would be excluded from participation under this provision, just as they are excluded from enrolling for supplementary medical insurance.

The bill would require, as the law now requires for making medicare protection available to uninsured persons aged 65 and over, that in order for persons to be eligible to enroll for hospital insurance they must be enrolled for supplementary medical insurance. If a person terminates his supplementary medical insurance, his hospital insurance coverage under this provision would be automatically terminated effective the same date as his supplementary medical insurance termination. The committee believes that such a restriction is necessary to reduce the possibility of excessive utilization of the more expensive hospital insurance coverage as might occur if an individual were enrolled for hospital insurance (covering primarily institutional care) but not for supplementary medical insurance (covering primarily outpatient care).

Coverage would be initially available as of April 1, 1978, to enrolled eligible persons.

Treatment of Professional Standards Review Organizations for Purposes of Internal Revenue Code (Section 27)

The committee bill amends the Internal Revenue Code to specifically include PSRO's as organizations eligible for section 501(c)(3) tax status.

Current law does not specify the tax status for PSRO's. Since the inception of the program, PSRO's have been engaged in a discussion with the Internal Revenue Service concerning whether they should be placed in a 501(c)(3) or a 501(c)(6) status. Both designations

(I) provides for financial participation by the State in the provision of the services described in section 2002(a)(1)[.]; and

(J) provides that any entity (other than an individual practitioner or a group of practitioners) receiving payments for the provision of health-related services complies with the requirements of section 1124, and supplies (within such period as may be specified in regulations by the Secretary or by the single State agency which administers or supervises the administration of the plan) upon request specifically addressed to such entity by the Secretary or such State agency, respectively, (i) full and complete information as to the ownership of a subcontractor (as defined by the Secretary in regulations) with whom such entity has had, during the previous twelve months, business transactions in an aggregate amount in excess of $25,000, and (ii) full and complete information as to any significant business transactions (as defined by the Secretary in regulations), occurring during the five-year period ending on the date of such request, between such entity and any wholly owned supplier or between such entity and any subcontractor.

SECTION 332 OF THE PUBLIC HEALTH SERVICE ACT

DESIGNATION OF HEALTH MANPOWER SHORTAGE AREAS

SEC. 332. (a)(1) * * *

* * * * * * *

(c) In determining whether to make a designation, the Secretary shall take into consideration the following:

(1)(A) The recommendations of each health systems agency (designated under section 1515) for a health service area which includes all or any part of the area, population group, medical facility, or other public facility under consideration for designation.

(B) The recommendations of the State health planning and development agency (designated under section 1521) if such area, population group, medical facility, or other public facility is within a health service area for which no health systems agency has been designated.

(2) The recommendations of the Governor of each State in which the area, population group, medical facility, or other public facility under consideration for designation is in whole or part located.

(3) The extent to which individuals who are (A) residents of the area, members of the population group, or patients in the medical facility or other public facility under consideration for designation, and (B) entitled to have payment made for medical services under title XVIII or XIX of the Social Security Act, cannot obtain such services because of suspension of physicians from the programs under such titles.

* * * * * * *

(Public Law 94-505)

AN ACT To authorize conveyance of the interests of the United States in certain lands in Salt Lake County, Utah, to Shriners' Hospitals for Crippled Children, a Colorado corporation.

* * * * * * *

TITLE II—OFFICE OF INSPECTOR GENERAL

DUTIES AND RESPONSIBILITIES

SEC. 203. (a) It shall be the duty and responsibility of the Inspector General—

(1) to supervise, coordinate, and provide policy direction for auditing and investigative activities relating to programs and operations of the Department;

(2) to recommend policies for, and to conduct, supervise, or coordinate other activities carried out or financed by the Department for the purpose of promoting economy and efficiency in the administration of, or preventing and detecting fraud and abuse in, its programs and operations;

(3) to recommend policies for, and to conduct, supervise, or coordinate relationships between the Department and other Federal agencies, State and local governmental agencies, and nongovernmental entities with respect to (A) all matters relating to the promotion of economy and efficiency in the administration of, or the prevention and detection of fraud and abuse in, programs and operations administered or financed by the Department, or (B) the identification and prosecution of participants in such fraud or abuse; [and]

(4) to keep the Secretary and the Congress fully and currently informed, by means of the reports required by section 4 and otherwise, concerning fraud and other serious problems, abuses, and deficiencies relating to the administration of programs and operations administered or financed by the Department, to recommend corrective action concerning such problems, abuses, and deficiencies, and to report on the progress made in implementing such corrective action[.]*; and*

(5) to bring civil actions on behalf of the United States in cases of alleged civil fraud relating to any health related program established or totally or partially funded under any provision of the Social Security Act, if no such civil action has been initiated by the Department of Justice within a period of six months following a formal referral of such case of alleged fraud by the Department to the Department of Justice and when such action is appropriate in the opinion of the Inspector General.

(b) In carrying out the responsibilities specified in subsection (a)(1), the Inspector General shall have authority to approve or disapprove the use of outside auditors or to take other appropriate steps to insure the competence and independence of such auditors.

(c) In carrying out the duties and responsibilities provided by this Act, the Inspector General shall give particular regard to the activities of the Comptroller General of the United States with a view to avoiding duplication and insuring effective coordination and cooperation.

REPORTS

SEC. 204. (a) The Inspector General shall, not later than March 31 of each year, submit a report to the Secretary and to the Congress summarizing the activities of the Office during the preceding calendar year. Such report shall include, but need not be limited to—

(1) an identification and description of significant problems, abuses, and deficiencies relating to the administration of programs and operations of the Department disclosed by such activities;

(2) a description of recommendations for corrective action made by the Office with respect to significant problems, abuses, or deficiencies identified and described under paragraph (1);

(3) an evaluation of progress made in implementing recommendations described in the report or, where appropriate, in previous reports; and

(4) a summary of matters referred to prosecutive authorities and the extent to which prosecutions and convictions have resulted.

Such report shall also include an evaluation of the performance of the Attorney General in the investigation and prosecution of criminal violations relating to fraud in the programs of health insurance and medical assistance provided under titles XVIII and XIX of the Social Security Act, and shall include any recommendations with respect to improving the performance of such activities.

* * * * * * *

SOCIAL SECURITY AMENDMENTS OF 1967

* * * * * * *

INCENTIVES FOR ECONOMY WHILE MAINTAINING OR IMPROVING QUALITY IN THE PROVISION OF HEALTH SERVICES

SEC. 402. (a) (1) * * *

* * * * * * *

"(H) to establish an experimental program to provide day-care services, which consist of such personal care, supervision, and services as the Secretary shall by regulation prescribe, for individuals eligible to enroll in the supplemental medical insurance program established under part B of title XVIII and title XIX of the Social Security Act, in day-care centers which meet such standards as the Secretary shall by regulation establish; [and]

"(I) to determine whether the services of clincal psychologists may be made more generally available to persons eligible for services under titles XVIII and XIX of this Act in a manner consistent with quality of care and equitable and efficient administration[.]*; and*

"(J) to develop or demonstrate improved methods for the investigation and prosecution of fraud in the provision of care or services under the health programs established by the Social Security Act.".

SELECTED PROVISIONS OF THE INTERNAL REVENUE CODE OF 1954

26 U.S.C. 1—

Subtitle A—Income Taxes

CHAPTER 1—NORMAL TAXES AND SURTAXES

* * * * * * *

Subchapter F—Exempt Organizations

PART I—GENERAL RULE

SEC. 501. Exemption From Tax On Corporations, Certain Trusts, Etc.

* * * * * * *

(i) PROHIBITION OF DISCRIMINATION BY CERTAIN SOCIAL CLUBS.—Notwithstanding subsection (a), an organization which is described in subsection (c)(7) shall not be exempt from taxation under subsection (a) for any taxable year if, at any time during such taxable year, the charter, bylaws, or other governing instrument, or such organization contains a provision which provides for discrimination against any person on the basis of race, color, or religion.

"(j) PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS.—For purposes of this title, a Professional Standards Review Organization designated as such by the Secretary of Health, Education, and Welfare under the provisions of part B of title XI of the Social Security Act (including an organization designated under section 1154 of such Act) shall be treated as an organization organized and operated exclusively for charitable purposes.".

[(j)]*(k)* CROSS REFERENCE.—

For nonexemption of Communist-controlled organizations, see section 11(b) of the Internal Security Act of 1950 (64 Stat. 997; 50 U.S.C. 790(b)).

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95TH CONGRESS } HOUSE OF REPRESENTATIVES { REPORT
1st Session } { No. 95-673

MEDICARE-MEDICAID ANTI-FRAUD AND ABUSE AMENDMENTS

OCTOBER 11, 1977.—Ordered to be printed

Mr. ULLMAN, from the committee of conference,
submitted the following

CONFERENCE REPORT

[To accompany H.R. 3]

The committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 3) to strengthen the capability of the Government to detect, prosecute, and punish fraudulent activities under the medicare and medicaid programs, and for other purposes, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the Senate amendment insert the following:

SHORT TITLE

SECTION 1. This Act may be cited as the "Medicare-Medicaid Anti-Fraud and Abuse Amendments".

PROHIBITION AGAINST ASSIGNMENT BY PHYSICIANS AND OTHERS OF CLAIMS FOR SERVICES; CLAIMS PAYMENT PROCEDURES FOR MEDICAID PROGRAM

SEC. 2. (a)(1) Section 1842(b)(5) of the Social Security Act is amended by adding at the end thereof the following new sentence: "No payment which under the preceding sentence may be made directly to the physician or other person providing the service involved (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) shall be made to anyone else under a reassignment or power of attorney (except to an employer or facility as described in clause (A) or (B) of such sentence); but nothing in this subsection shall be construed (i) to prevent the making of such a payment in accordance with an assignment from the individual to whom the service was provided or a reassignment from the physician or other person providing such service if such assignment or reassignment is made to a govern-

JOINT EXPLANATORY STATEMENT OF THE COMMITTEE OF CONFERENCE

The managers on the part of the House and the Senate at the conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 3) to strengthen the capability of the Government to detect, prosecute, and punish fraudulent activities under the medicare and medicaid programs, and for other purposes, submit the following joint statement to the House and the Senate in explanation of the effect of the action agreed upon by the managers and recommended in the accompanying conference report:

The Senate amendment struck out all of the House bill after the enacting clause and inserted a substitute text.

The House recedes from its disagreement to the amendment of the Senate with an amendment which is a substitute for the House bill and the Senate amendment. The differences between the House bill, the Senate amendment, and the substitute agreed to in conference are noted below, except for clerical corrections, conforming changes made necessary by agreements reached by the conferees, and minor drafting and clarifying changes.

1. REQUIREMENTS FOR TIMELY PAYMENT BY STATE MEDICAID AGENCIES (SECTION 2)

House bill.—The House bill requires States to make provision in their State medicaid plan for claims payment procedures which ensure that 90 percent of the bills submitted by eligible noninstitutionally-based providers will be reimbursed within 30 days, and 99 percent within 60 days. The State would not be cited for noncompliance if the Secretary found the State was acting in good faith to achieve this goal. The provision is effective for calendar quarters beginning on or after January 1, 1978.

Senate amendment.—The Senate amendment follows the House bill, except that it requires that 95 percent of claims be paid within 30 days, and 99 percent within 90 days. The provision is effective for calendar quarters beginning on or after July 1, 1978.

Conference agreement.—The conference agreement requires States to make provision in their State medicaid plan for claims payment procedures which assure that 90 percent of the bills submitted by eligible non-institutionally based providers will be reimbursed within 30 days, and 99 percent within 90 days. This standard would be applied to clean claims, that is, those not requiring further substantiation.

The conference agreement accepts the Senate amendment regarding the effective date.

2. INCENTIVE PAYMENT FOR STATE PROGRAMS OF EDUCATIONAL AND TECHNICAL ASSISTANCE TO EXPEDITE FILING AND PAYMENT OF CLAIMS (SECTION 2)

House bill.—The House bill authorizes 90 percent Federal matching from January 1978 through September 1980 for the costs attributable to the conduct of educational and technical assistance programs for health care practitioners which the Secretary determines are likely to expedite the filing and payment of claims, with a maximum on total quarterly Federal payments under the provision of $1.25 million.

Senate amendment.—The Senate amendment contains no comparable provision.

Conference agreement.—The conference agreement accepts the Senate position.

3. PROGRAMS SUBJECT TO DISCLOSURE (SECTION 3)

House bill.—The House bill requires disclosure of ownership information for specified entities in medicare (title XVIII), medicaid (title XIX), and the maternal and child health (title V) programs.

Senate amendment.—The Senate amendment is the same as House bill, but adds the social service grant program (title XX) to the list of programs requiring disclosure.

Conference agreement.—The conference agreement accepts the Senate amendment.

4. ENTITIES SUBJECT TO DISCLOSURE (SECTION 3)

House bill.—The House bill contains no provision relating to health maintenance organizations.

Senate amendment.—The Senate amendment adds health maintenance organizations to the list of entities required to disclose ownership under the bill.

Conference agreement.—The conference agreement accepts the Senate amendment.

5. SUBCONTRACTOR OWNERSHIP DISCLOSURE (SECTION 3)

House bill.—The House bill requires a provider of services (hospital, skilled nursing facility, or home health agency) to disclose information relating to the identity of subcontractors that are 5 percent or more owned by the provider.

Senate amendment.—The Senate amendment extends the subcontractor ownership disclosure of the House bill to include all other disclosing entities under the bill (i.e., other medicaid providers, intermediaries, carriers, HMO's, and title XX (social services) providers).

Conference agreement.—The conference agreement accepts the Senate amendment.

6. MEDICAID DISCLOSURE EFFECTIVE DATE (SECTION 3)

House bill.—The House bill provides for an effective date of October 1, 1977, for medicaid disclosure provisions.

Senate amendment.—The Senate amendment changes the effective date to January 1, 1978.

Conference agreement.—The conference agreement accepts the Senate amendment.

7. FORCED CONTRIBUTIONS FOR ADMISSION TO FACILITY (SECTION 4)

House bill.—The House bill defines as a felony instances where contributions are required as a condition of entry or continued stay at a hospital, skilled nursing facility, or intermediate care facility for patients whose care is financed in whole or in part by medicaid.

Senate amendment.—The Senate amendment deletes the provision.

Conference agreement.—The conference agreement accepts the House provision.

8. EMPLOYMENT PAYMENT EXCEPTION (SECTION 4)

House bill.—The House bill provides, in defining kickbacks in the penalty statutes, that remuneration that is an amount paid "by an employer to an employee for employment in the provision of covered items or services" is exempt.

Senate amendment.—The Senate amendment is the same as House bill, but adds clarifying language that the employee must have a "bona fide" employment relationship with the employer.

Conference agreement.—The conference agreement accepts the Senate amendment.

9. MEDICARE ASSIGNMENT MISDEMEANOR (SECTION 4)

House bill.—The House bill contains no provision.

Senate amendment.—The Senate amendment provides that it would be a misdemeanor for a physician to willfully and knowingly violate his agreement not to charge a medicare patient more than the coinsurance and any unmet deductible amount when he agrees to accept assignment of the patient's right to receive payment.

Conference agreement.—The conference agreement accepts the Senate amendment with a modification to make clear that this misdemeanor is to apply only to situations where an individual has knowingly, willfully and repeatedly violated medicare assignment agreements.

10. PSRO REIMBURSEMENT ARRANGEMENT (SECTION 5(C))

House bill.—The House bill provides that arrangements with PSRO's for reimbursement of the cost of review activities are to be made in a manner similar to that provided for medicare intermediaries.

Senate amendment.—The Senate amendment includes the provision of the House bill and further provides that arrangements with PSRO's for reimbursement of the cost of review activities may be in the form of an assistance agreement.

Conference agreement.—The conference agreement accepts the Senate amendment.

11. PSRO REVIEW METHODOLOGIES (SECTION 5(C))

House bill.—The House bill requires the development of ambulatory care review methodologies by the Secretary for use by PSRO's.

Senate amendment.—The Senate amendment deletes the requirement in the House bill.

Conference agreement.—The conference agreement accepts the Senate amendment.

12. PSRO AMBULATORY CARE REVIEW SECTION (5(C))

House bill.—The House bill requires each PSRO to undertake ambulatory care review not later than 2 years after it has achieved operational status.

Senate amendment.—The Senate amendment is the same as the House bill, but adds clarifying language to permit a qualified PSRO to undertake ambulatory care review at an earlier date where the PSRO requests authority to conduct such review and is found capable to do so by the Secretary, but in no case could the Secretary require a PSRO to conduct such reviews before it achieves operational status.

Conference agreement.—The conference agreement accepts the Senate amendment.

13. STANDARD STATE MUST MEET TO DEMONSTRATE UNSATISFACTORY PSRO PERFORMANCE, AND REQUIRED SECRETARIAL ACTION (SECTION 5(d))

House bill.—The House bill provides that when a State agency monitoring the performance of a PSRO submits reasonable documentation that the PSRO decisions have caused an unreasonable and detrimental impact on *either* total State medicaid expenditures *or* on the quality of care, the Secretary shall temporarily suspend the PSRO's binding review authority for medicaid within 30 days, pending Secretarial reevaluation of the PSRO performance.

Senate amendment.—The Senate amendment provides that when a State agency monitoring the performance of a PSRO submits reasonable documentation that the PSRO decisions have caused an unreasonable and detrimental impact on total State medicaid expenditures *and* on the quality of care, the Secretary shall make a determination of the reasonableness of the State allegation within 30 days; if he determines that the PSRO decisions have had an unreasonable and detrimental impact on expenditures and quality, he may suspend the PSRO's binding authority for medicaid. The Senate amendment further provides that such action by the Secretary is final and not subject to judicial review.

Conference agreement.—The conference agreement provides that when a State agency monitoring the performance of a PSRO submits reasonable documentation that the PSRO decisions have caused an unreasonable and detrimental impact on total State medicaid expenditures and on the appropriateness of care received. the Secretary shall make a determination of the reasonableness of the State allegation within 30 days. If he determines that the State allegation is correct, he must suspend the PSRO's binding authority under medicaid immediately, unless he determines corrective action has already been taken. The suspension is effective pending Secretarial reevaluation of the PSRO's performance and reinstatement of the PSRO's authority. The conferees would note that a demonstration that PSRO decisions have had a detrimental impact on medicaid program costs would not be grounds for removing the binding authority of a PSRO under title XIX unless it was also demonstrated that this occurred because the PSRO was approving inappropriate care or services with such regularity that program costs were significantly affected.

The conference agreement further provides that such action by the Secretary is final and not subject to judicial review.

14. PSRO DELEGATION REVIEW RESPONSIBILITY TO SKILLED NURSING FACILITY THAT IS PART OF A HOSPITAL (SECTION 5(d))

House bill.—The House bill provides that a PSRO may not delegate review responsibilities to the review committee of a skilled nursing facility.

Senate amendment.—The Senate amendment provides that a PSRO may not delegate review responsibilities to the review committee of a skilled nursing facility, unless that facility (or an intermediate care facility) is part of a hospital where the PSRO is utilizing the services of the hospital's review committee.

Conference agreement.—The conference agreement generally follows the Senate amendment with a modification clarifying that a PSRO may not delegate review responsibilities to a skilled nursing facility or an intermediate care facility unless that facility is part of a hospital to which the PSRO has delegated review.

15. PRIMACY FOR REVIEW OF SERVICES IN INTERMEDIATE CARE FACILITIES (SECTION 5(d))

House bill.—The House bill provides that a PSRO has responsibility for review of services in intermediate care facilities and in public institutions for the mentally retarded only if the Secretary finds that the State is not performing effective review of the quality and necessity of services in these facilities.

Senate amendment.—The Senate amendment follows the House provision, except it provides that a PSRO will perform review in an intermediate care facility where that facility is also a skilled nursing facility.

Conference agreement.—The conference agreement provides that a PSRO has responsibility for review of services in intermediate care facilities and in public institutions for the mentally retarded only if (i) the Secretary finds that the State is not performing effective review of the quality and necessity of services in these facilities, or (ii) the State requests that the PSRO be responsible for the review and waives its right to be the primary reviewer of intermediate care facility services. Additionally, in the case of facilities which provide both skilled nursing facility services and intermediate care facility services, if the Secretary finds that review of the skilled nursing facility services by the PSRO, and of the intermediate care facility services by the State, would be inefficient, he may assign review responsibility for all patients in the facility to the PSRO. The conferees understand that the Secretary may determine that the arrangement is sufficiently inefficient to justify assignment of review rights to the PSRO in any single joint facility, or in classes of facilities, such as those facilities where the proportion of intermediate care facility patients is such that separate review would pose an unjustified administrative burden.

16. NATIONAL COUNCIL MEMBERSHIP (SECTION 5(f))

House bill.—The House bill provides for staggered terms for members of the National Professional Standards Review Council effective with appointments made in 1979.

Senate amendment.—The Senate amendment is the same as the House bill, except that the effective date is changed to 1977.

Conference agreement.—The conference agreement provides for staggered terms for members of the Council beginning with any terms which, under existing law, expire on or after January 1, 1978.

17. ANNUAL REPORT ON PSRO PROGRAM (SECTION 5(*k*))

House bill.—The House bill requires the Secretary to submit an annual report to the Congress on the administration and cost of the PSRO program.

Senate amendment.—The Senate amendment is the same as the House bill, except that it modifies the description of specific data required to be included in the report with respect to medically unnecessary services and ambulatory care review methodologies.

Conference agreement.—The conference agreement accepts the Senate amendment.

18. PHYSICIAN REVIEW (SECTION 5(p))

House bill.—There is no provision in the House bill.

Senate amendment.—The Senate amendment deletes the restriction in present law which prevents physicians with staff privileges in a hospital from being responsible for review of services in the facility if review responsibilities have not been delegated to the hospital by the PSRO.

Conference agreement.—The conference agreement accepts the Senate amendment.

19. SCOPE OF GAO SUBPENA POWER (SECTION 6)

House bill.—The House bill authorizes the Comptroller General (GAO) to issue subpenas in his work on Social Securty Act health programs.

Senate amendment.—The Senate amendment authorizes the subpenas to be issued in connection with GAO work on any Social Security Act program.

Conference agreement.—The conference agreement accepts the Senate amendment.

20. GAO DISCLOSURE OF INFORMATION (SECTION 6)

House bill.—The House bill contains provisions relating to the disclosure by the GAO of medical records information in its possession.

Senate amendment.—The Senate amendment deletes this provision.

Conference agreement.—The conference agreement accepts the Senate amendment.

21. COURT ACCESS TO GAO INFORMATION (SECTION 6)

House bill.—The House bill contains a provision to exempt from subpena or discovery proceedings in a civil action personal medical records in the possession of the General Accounting Office.

Senate amendment.—The Senate amendment deletes this provision.

Conference agreement.—The conference agreement accepts the House provision.

22. EFFECTIVE DATE FOR SUSPENSION OF MEDICAID PROVIDERS (SECTION 7)

House bill.—In the House bill the effective date for the suspension provision under medicaid is October 1, 1977.

Senate amendment.—In the Senate amendment, the effective date is January 1, 1978.

Conference agreement.—The conference agreement accepts the Senate amendment.

23. ASSIGNMENT OF RIGHTS TO MEDICAL SUPPORT AS CONDITION OF MEDICAID ELIGIBILITY; ESTABLISHMENT OF STATE PROGRAM TO COLLECT SUPPORT (SECTION 11)

House bill.—The House bill contains no provision.

Senate amendment.—The Senate amendment adds a provision to establish a medical support program under which medicaid applicants and recipients may be required by a State to assign their rights to medical support or indemnification to the State. An incentive in the form of a federal payment of 15 percent of amounts collected (in place of amounts which would otherwise be provided for medical assistance) would be provided for localities to make collections for States, and for States to secure collections in behalf of other States.

Conference agreement.—The conference agreement accepts the Senate provision with an amendment to clarify that the State agency designated to administer the State plan for child support and establishment of paternity under part D of title IV of the Social Security Act may be used for the enforcement of rights due from or through an absent parent to pay for medical care. The conferees intend that the title IV part D agency should be used to the maximum extent feasible. It is not intended that title XIX agencies establish new and separate systems for collection and enforcement of support from absent parents for payment for medical care apart from child support enforcement programs which are already established in States under the provisions of part D of title IV, since doing so would foster duplication of effort, unnecessary expense, and administrative complexity. It is expected that the program established under this section will establish adequate procedures to safeguard information and assure that a timely and simple mechanism exists to reassign rights to medical support of the individual entitled to that support if the individual's eligibility for medical assistance under title XIX is terminated.

24. NOMINATION OF INTERMEDIARIES (SECTION 14)

House bill.—The House bill authorizes the Secretary, after applying appropriate standards and criteria, to assign providers to available intermediaries and to designate a regional or national intermediary for a class of providers where he determines that such actions will result in more effective and efficient administration of the program. In such cases, the Secretary must provide the intermediary an explanation of the reasons for his determination and opportunity for a hearing. Such determinations would be subject to judicial review.

Senate amendment.—The Senate amendment deletes this provision of the House bill and substitutes a provision under which the Secretary would be prohibited from refusing to enter into or renew an agreement with a provider-nominated intermediary solely because of the fact that such intermediary serves providers located only in a single State or that the provider could be served by a different intermediary which serves providers in more than one State.

Conference agreement.—The conference agreement accepts the House language with modification to clarify those areas for which the Secretary will have to establish standards, criteria and procedures to determine whether the Secretary should enter into, renew, or terminate an agreement with an intermediary and to determine when to assign or reassign providers to intermediaries. This clarification also incorporates that part of the Senate amendment that provides that any standards and criteria established should not have the effect of excluding an agency or organization from being an intermediary solely because it operates in one State.

The clarification added by the conferees requires that the Secretary develop standards, criteria and procedures to serve as a basis for determining what constitutes effective and efficient administration. These standards and criteria would be applied in addition to those that he will also establish for the purpose of evaluating an intermediary's performance with respect to all providers or specific providers. Because of the random distribution of providers to intermediaries, both in numbers and by type of institution, there can be intermediaries with high administrative costs, lengthy processing times or other difficulties in handling claims and audit functions through no fault of their own. The intent is to make clear that the Secretary in such instances would have authority to assign or reassign providers to achieve a distribution of providers that would improve the efficiency and effectiveness of the medicare program as defined in criteria and standards.

25. AMOUNT OF INCENTIVES TO ESTABLISH STATE MEDICAID FRAUD UNITS (SECTION 17)

House bill.—The House bill provides incentives for the establishment and operation of State medicaid fraud units through the provision for 90 percent Federal funding for the period October 1, 1977, through September 30, 1980, subject to an annual maximum payment of 1 percent of medicaid expenditures in a State, or $500,000, whichever is greater.

Senate amendment.—The Senate amendment follows the House bill, except that it provides for 100 percent Federal funding during fiscal year 1978, 90 percent during fiscal year 1979, and 75 percent during fiscal year 1980, subject to the same maximum amounts in the House bill.

Conference agreement.—The conference agreement accepts the House provision with respect to the level of Federal funding. These Federal monies are to be paid directly to the qualifying State medicaid anti-fraud agency.

26. REQUIREMENT FOR LOCATION OF FRAUD UNIT (SECTION 17)

House bill.—The House bill provides that to be eligible for increased Federal matching payments, a fraud unit must be separate from the single State agency administering medicaid. In addition it must be (a) in an agency with statewide prosecuting authority, or (b) if the constitution prohibits statewide prosecuting authority, an agency with satisfactory procedures to assure prosecution by the appropriate authorities.

Senate amendment.—The Senate amendment provides that to be eligible for increased Federal matching, the unit must be separate from the medicaid operating agency, or (if different) the single State agency administering medicaid.

In addition, the unit must be: (a) in an agency with statewide prosecuting authority, or (b) if the constitution prohibits statewide prosecuting authority, an agency with satisfactory procedures to assure prosecution, or (c) an entity with formal procedures and a working relationship, satisfactory to the Secretary, for coordination with the State attorney general's office.

Conference agreement.—The conference agreement deletes the Senate amendment regarding the placement of the unit relative to the State medicaid agency. The conferees note that the intent of the Senate amendment was the same as the House provision, and the conference action represents only a technical change.

The conference agreement includes the Senate amendment permitting increased matching for an entity with formal procedures and a working relationship, satisfactory to the Secretary, for coordination with the State attorney general's office.

27. DEMONSTRATION AUTHORITY FOR IMPROVED METHODS TO INVESTIGATE AND PROSECUTE FRAUD IN MEDICARE AND MEDICAID (SECTION 17)

House bill.—The House bill contains no provision.

Senate amendment.—The Senate amendment authorizes experiments and demonstrations to develop or demonstrate improved methods for investigation and prosecution of fraud in medicare and medicaid.

Conference agreement.—The conference agreement accepts the Senate amendment.

28. UNIFORM REPORTING (SECTION 19)

House bill.—The House bill requires the Secretary to establish for each of the different types of health services institutions a uniform system for the reporting of such items as cost of operation, volume of services, rates, capital assets and bill data. This reporting system would be mandated for use by medicare and medicaid providers and such use would be phased in by type of provider.

Senate amendment.—The Senate amendment is the same as the House bill, with the additional requirement that hospitals shall use the chart of accounts, definitions, principles and statistics prescribed by the Secretary to reach a uniform reconciliation of financial and statistical data for reports to the Secretary.

Conference agreement.—The conference agreement accepts the Senate amendment. It is the intent of the conferees in agreeing to the Senate amendment that the reconciliation of data not be required on a day-to-day basis but only at such times as the uniform reports are required, and only for purposes of such reports.

29. CONDITIONS FOR WAIVER OF PAST PENALTIES FOR FAILURE TO PERFORM REQUIRED REVIEW OF INSTITUTIONAL CARE (SECTION 20)

House bill.—The House bill allows States additional time to meet the requirements of the current law concerning review of care delivered in long-term care institutions, by providing that if a State is in compliance for the calendar quarter ending December 31, 1977, the Secretary shall waive all previously assessed reductions which would otherwise be imposed on those States that failed to fulfill the requirements of the law during previous periods.

Senate amendment.—The Senate amendment provides for unconditional waiver of all reductions in medicaid payments due to an unsatisfactory or invalid showing made with respect to a calendar quarter beginning prior to January 1, 1978.

Conference agreement.—The conference agreement provides that all penalties assessed against States for unsatisfactory or invalid showings made with respect to calendar quarters beginning prior to January 1, 1977, shall be waived unconditionally. It further provides that if a State is in compliance with the requirements of the law for the calendar quarter ending December 31, 1977, the Secretary shall waive all penalties for unsatisfactory or invalid showings for quarters occurring in 1977; if the State is not in compliance on December 31 and past penalties are imposed, the penalty will be determined by taking into account the proportion of medicaid patients in homes that were not reviewed to all medical patients in homes to be reviewed.

30. FORMULA FOR REDUCTION IN FEDERAL MATCHING FOR FAILURE TO CARRY OUT REVIEW (SECTION 20)

House bill.—The House bill contains no provision. Therefore, it retains the current law formula for a one-third reduction of Federal matching funds for days of care beyond 60 in a hospital ,a skilled nursing facility, or an intermediate care facility, and beyond 90 in a mental hospital, if adequate review is not carried out in accordance with the requirements of the law.

Senate amendment.—The Senate amendment adjusts the reduction by the proportion of patients not reviewed to total patients in facilities to be reviewed.

Conference agreement.—The conference agreement accepts the Senate amendment, with clarification that (i) it is effective for quarters beginning after December 31, 1976, and (ii) that the reduction reflects the proportion of medicaid patients in facilities for which there is an unsatisfactory or invalid showing to total medicaid patients in facilities to be reviewed.

31. CONDITIONS FOR WAIVER OF REDUCTIONS FOR FAILURE TO PERFORM REVIEW (SECTION 20)

House bill.—The House bill specifies that if a State makes a good faith attempt to perform reviews of all institutions, and actually reviews all large institutions and 98 percent of all other institutions, it will be considered in full compliance with the requirements of the law.

Senate amendment.—The Senate amendment provides that the Secretary may waive any reduction in Federal matching percentage if he determines that the State's noncompliance is technical or due to circumstances beyond control of the State.

Conference agreement.—The conference agreement provides that good faith attempts to perform reviews of all institutions, and actually reviews all large institutions and 98 percent of all other institutions (or fails to meet this standard only for technical reasons), it will be considered in full compliance with the requirements of the law. The conferees stress that the intent of the law that *all* facilities be reviewed is not changed by this provision. If a facility is not reviewed, there will be a reduction in matching unless the Secretary finds there was a good faith attempt to review the institution, and there is no evidence that any institution, or kind or type of institution, is deliberately not reviewed.

32. COMPOSITION OF MEDICAL REVIEW TEAMS (SECTION 20)

House bill.—The House bill contains no provision.

Senate amendment.—The Senate amendment provides that medical review teams reviewing care in skilled nursing facilities may be composed of physicians *or* registered nurses (current law requires that physicians be on the team).

Conference agreement.—The conference agreement accepts the Senate amendment.

33. PROTECTION OF PATIENT FUNDS (SECTION 21, ADDED BY THE SENATE AMENDMENT

House bill.—The House bill contains no provision.

Senate amendment.—The Senate amendment requires that, as a condition for participation in the medicare and medicaid programs, a skilled nursing facility must establish and maintain a system to assure the proper accounting of personal funds. Such system must provide for separate and discreet accounting for each patient with a complete accounting of income and expenditures.

Conference agreement.—The conference agreement accepts the Senate amendment.

34. GRACE PERIOD FOR POST DISCHARGE CARE (SECTION 22, ADDED BY THE SENATE AMENDMENT)

House bill.—The House bill contains no provision.

Senate amendment.—The Senate amendment provides that when a PSRO determines that further institutional care is not medically necessary, payment may be made for only one additional day, except that a PSRO may authorize up to 3 additional days on a case-by-case basis where additional time is needed to arrange for necessary post-discharge care.

Conference agreement.—The conference agreement accepts the Senate amendment.

35. PROSECUTION OF CIVIL FRAUD BY INSPECTOR GENERAL (SECTION 23, ADDED BY THE SENATE AMENDMENT)

House bill.—The House bill contains no provision.

Senate amendment.—The Senate amendment authorizes prosecution of civil fraud cases under the Social Security Act health care programs by the Inspector General of HEW where U.S. attorneys have not initiated proceedings within 6 months of a formal referral of a case.

Conference agreement.—The conference agreement does not include the prosecution authority proposed by the Senate amendment but does provide that in addition to the requirements imposed on the Inspector General of the Department of Health, Education and Welfare by section 4(c) of the bill, the Inspector General shall annually include a report to the Congress information related to the Social Security Act cases referred by the Department of Health, Education and Welfare to the Department of Justice for prosecution. This information shall include for each case a description of the number of cases referred (without individual identifiers), the types of illegal activity involved, and the amount in controversy. The Attorney General shall be required to respond to the annual report of the Inspector General by specifying the date of referral, district to which referred, and disposition of each case referred by the Department of Health, Education, and Welfare as specified in the report of the Inspector General to the Congress.

36. UTILIZATION REVIEW DEMONSTRATION PROJECTS (SECTION 24, AS ADDED BY THE SENATE AMENDMENT)

House bill.—The House bill contains no provision.

Senate amendment.—The Senate amendment directs the Secretary to establish demonstration projects to evaluate the effectiveness of PSRO reviews compared to alternative State review methods. It authorizes establishment of such projects in States which had operating onsite State evaluation systems in place on August 5, 1977, and which make application to the Secretary prior to April 1, 1978. It specifies that demonstration projects be conducted in PSRO areas which are representative of a State's medicaid population and that they be conducted in areas which comprise a significant proportion of medicaid patient days.

Conference agreement.—The conference agreement accepts the House position.

37. PAYMENT FOR CERTAIN HOSPITAL SERVICES PROVIDED IN VETERANS' ADMINISTRATION HOSPITALS (SECTION 25, ADDED BY THE SENATE AMENDMENT)

House bill.—The House bill contains no provision.

Senate amendment.—The Senate amendment authorizes, under certain circumstances, medicare reimbursement for care provided to a nonveteran medicare beneficiary in a Veterans' Administration hospital where the care was provided on the mistaken (but good faith) assumption that the beneficiary was an eligible veteran. The provision would be applicable to care furnished on or after July 1, 1974.

Conference agreement.—The conference agreement accepts the Senate amendment.

38. HOSPITAL INSURANCE FOR CERTAIN INDIVIDUALS, AGE 60 THROUGH 64 (SECTION 26, ADDED BY THE SENATE AMENDMENT)

House bill.—The House bill contains no provision.

Senate amendment.—The Senate amendment would make medicare protection (parts A and B) available on an optional basis for spouses aged 60–64 of medicare beneficiaries, others aged 60–64 who are entitled to retirement or other dependents' benefits under social security; and disability beneficiaries aged 60–64 not otherwise eligible for medicare. Persons who elect to enroll under this provision would pay the cost of such protection.

Conference agreement.—The conference agreement accepts the House position.

39. TREATMENT OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS FOR PURPOSES OF THE INTERNAL REVENUE CODE (SECTION 27, ADDED BY THE SENATE AMENDMENT)

House bill.—The House bill contains no provision.

Senate amendment.—The Senate amendment deems PSRO's, for purposes of determining tax-exempt status under section 501(c)(3) of the Internal Revenue Code, to be organizations organized and operated exclusively for charitable purposes.

Conference agreement.—The conference agreement accepts the House position.

40. POSTPONEMENT OF REQUIREMENT THAT STATE MEDICAID PROGRAMS PAY SKILLED NURSING FACILITIES AND INTERMEDIATE CARE FACILITIES ON A BASIS REASONABLY RELATED TO COST (SECTION 28, ADDED BY THE SENATE AMENDMENT)

House bill.—The House bill contains no provision.

Senate amendment.—The Senate amendment postpones the requirement for medicaid payments on a basis reasonably related to cost until January 1979, and provides protection against retroactive claims for failure to meet the current law requirements.

Conference agreement.—The conference agreement accepts the House position.

Managers on the Part of the Senate.

Al Ullman,
Dan Rostenkowski,
James C. Corman,
Otis G. Pike,
Charles A. Vanik,
Harley O. Staggers,
Paul G. Rogers,
David E. Satterfield,
Richardson Preyer,
James H. Scheuer,
Barber B. Conable, Jr.,
John J. Duncan,
Tim Lee Carter,
Edward R. Madigan,

Managers on the Part of the House.

Russell Long,
H. E. Talmadge,
Abe Ribicoff,
Carl T. Curtis,
Bob Dole,

○

Finder's Aid

P.L. 95-171 (91 Stat. 1353) Approved November 12, 1977

Subject	SS Act Section	P.L. Section	91 Stat.	H.Rep. 95-439	S.Rep. 95-456
AFDC--Increase Percent of Protective Pay Cases	403(a)	3(a)(1)	1354	--	1-3, 6-7
Adds Joint Payment Provisions	406(b)(2)	3(a)(2)	1354	--	1-3, 6-7
Distribution of Child Support Proceeds	457(c)	11	1357	--	--
Exclusion From SSI Income--Disaster Assistance	1612(b)(12)	8(a)	1355	--	--
Exclusion from SSI Resource--Disaster Relief Funds	1613(a)(6)	9(a)	1355	--	--

Public Law 95-171
95th Congress

An Act

To extend certain Social Security Act provisions, and for other purposes.

Nov. 12, 1977
[H.R. 3387]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Social Security Act, amendments.
42 USC 1397a note.

SECTION 1. (a) Section 3 of Public Law 94-401 is amended—

(1) by inserting "and the fiscal year ending September 30, 1978," after "1977," in the matter preceding paragraph (1) of subsection (a);

(2) by inserting "and such fiscal year ending September 30, 1978," after "1977," in subsection (a)(1)(B);

(3) by striking out "or fiscal year" in subsection (a)(2) and inserting in lieu thereof "or either such fiscal year";

(4) by striking out "or fiscal year" in subsections (b), (c)(1), and (c)(2)(A) and inserting in lieu thereof in each instance "or either fiscal year";

(5) by inserting ", or the fiscal year ending September 30, 1978" before the period at the end of subsection (d)(1); and

(6) by striking out "for such fiscal year" in subsection (d)(2) and inserting in lieu thereof "for either such fiscal year".

42 USC 1397a note.

(b) Section 5(b) of Public Law 94-401 is amended by striking out "September 30, 1977" and "October 1, 1977" and inserting in lieu thereof "September 30, 1978" and "October 1, 1978", respectively.

42 USC 1397a note.

(c) Section 6 of Public Law 94-401 is amended by striking out "September 30, 1977" and "October 1, 1977" and inserting in lieu thereof "September 30, 1978" and "October 1, 1978", respectively.

42 USC 1397b.
42 USC 1397 note.

(d) Section 7(a)(3) of Public Law 93-647 is amended by striking out "October 1, 1977" and inserting in lieu thereof "October 1, 1978".

26 USC 50B.

(e) Section 50B(a)(2)(B) of the Internal Revenue Code of 1954 (definition of Federal welfare recipient employment incentive expenses) is amended by striking out "October 1, 1977" and inserting in lieu thereof "October 1, 1978".

Effective date.
26 USC 50B note.

(f) The amendments made by this section shall be effective on October 1, 1977.

State unemployment compensation laws, approval.
26 USC 3304.

SEC. 2. (a) Section 3304(a)(6)(A) of the Internal Revenue Code (relating to approval of State unemployment compensation laws) is amended by striking out "and" at the end of clause (ii) and by adding at the end thereof the following new clause:

"Educational service agency."

> "(iv) with respect to any services described in clause (i) or (ii), compensation payable on the basis of services in any such capacity may be denied as specified in clauses (i), (ii), and (iii) to any individual who performed such services in an educational institution while in the employ of an educational service agency, and for this purpose the term 'educational service agency' means a governmental agency or governmental entity which is established and operated exclusively for the purpose of providing such services to one or more educational institutions, and".

26 USC 3304 note.

(b) The amendments made by subsection (a) shall apply with respect to weeks of unemployment which begin after December 31, 1977.

42 USC 603.

SEC. 3. (a) (1) Section 403(a) of the Social Security Act is amended by striking out "10" in each of the last two sentences and inserting in lieu thereof "20".

Families with dependent children, aid payments.
42 USC 606.

(2) Section 406(b) of such Act is amended—

(A) by striking out the semicolon at the end of clause (2)(E) and inserting in lieu thereof a period; and

(B) by adding at the end thereof (after and below clause (2)(E)) the following new sentences:

"Payments with respect to a dependent child which are intended to enable the recipient to pay for specific goods, services, or items recognized by the State agency as a part of the child's need under the State plan may (in the discretion of the State or local agency administering the plan in the political subdivision) be made, pursuant to a determination referred to in clause (2)(A), in the form of checks drawn jointly to the order of the recipient and the person furnishing such goods, services, or items and negotiable only upon endorsement by both such recipient and such person; and payments so made shall be considered for all of the purposes of this part to be payments described in clause (2). Whenever payments with respect to a dependent child are made in the manner described in clause (2) (including payments described in the preceding sentence), a statement of the specific reasons for making such payments in that manner (on which the determination under clause (2)(A) was based) shall be placed in the file maintained with respect to such child by the State or local agency administering the State plan in the political subdivision.".

Effective date.
42 USC 603 note.

(3) The amendments made by this subsection shall apply with respect to payments of aid to families with dependent children made for months beginning on or after October 1, 1977.

State aid plans, Federal financial participation.
42 USC 606 note.
42 USC 602.

42 USC 302 note.

(b) Notwithstanding any other provision of law, Federal financial participation in aid to families with dependent children under a State plan approved under section 402 of the Social Security Act, for quarters (with respect to which expenditure reports were timely filed by the State) during the period beginning with the calendar quarter in which Public Law 90-248 was enacted and ending with the first calendar quarter of 1977, shall not be denied, on or after October 1, 1977, by reason of the provision of goods, services, or items in the form of a check which is drawn jointly to the order of the recipient and the person furnishing such goods, services, or items and which shows the purpose for which the check is drawn, or by reason of the failure of the State to meet the requirement of the last two sentences of section 403(a) of such Act or the failure of the State (or any political subdivision thereof) to carry out the functions and duties prescribed in clauses (A), (B), (C), and (E) of section 406(b)(2) of such Act, regardless of the form in which the aid involved was paid, if (and to the extent that) the amount of such aid was correct and the payment of the aid in that form did not result in assistance in cases or in amounts not authorized by or under part A of title IV of such Act.

SEC. 4. (a) Section 167(k) of the Internal Revenue Code of 1954 (relating to depreciation of expenditures to rehabilitate low-income rental housing) is amended by striking out "January 1, 1978" each place it appears and inserting in lieu thereof "January 1, 1979".

26 USC 167.

(b) Section 203(b) of the Tax Reform Act of 1976 is amended by striking out ", and before January 1, 1978, and expenditures made pursuant to a binding contract entered into before January 1, 1978".

26 USC 167.

SEC. 5. Section 4(c) of the Act entitled "An Act to suspend until the close of June 30, 1975, the duty on certain carboxmethyl cellulose salts, and for other purposes", approved October 26, 1974 (Public Law 93-483), is amended to read as follows:

26 USC 117 note.

"(c) EFFECTIVE DATE.—The provisions of this section shall apply with respect to amounts received during calendar years 1973, 1974, and 1975, and, in the case of a member of a uniformed service receiving training after 1975 and before 1979 in programs described in subsection (a), with respect to amounts received after 1975 and before 1983."

Effective date.

SEC. 6. (a) Section 2(b) of Public Law 94-331 is amended by striking out "and before December 31, 1976".

42 USC 1382a note.

(b) The effective date of this section shall be the first day of the calendar quarter following enactment of this Act.

Effective date.
42 USC 1382a note.

SEC. 7. (a) Section 4(b) of Public Law 94-331 is amended by striking out "and before December 31, 1976".

42 USC 1382a note.

(b) The effective date of this section shall be the first day of the calendar quarter following enactment of this Act.

Effective date.
42 USC 1382a note.

SEC. 8. (a) Section 1612(b) of the Social Security Act is amended—

Interest income on assistance funds.
42 USC 1382a.

(1) by striking out "and" at the end of paragraph (10) thereof,

(2) by striking out the period at the end of paragraph (11) thereof and inserting in lieu of such period the following: "; and", and

(3) by adding after and below paragraph (11) thereof the following new paragraph:

"(12) interest income received on assistance funds referred to in paragraph (11) within the 9-month period beginning on the date such funds are received (or such longer periods as the Secretary shall by regulations prescribe in cases where good cause is shown by the individual concerned for extending such period).".

(b) The amendment made by this section shall be effective July 1, 1976, with respect to catastrophes which occurred on or after June 1, 1976, and before December 31, 1976. With respect to catastrophes which occurred on or after December 31, 1976, the amendment made by this section shall be effective the first day of the calendar quarter following enactment of this Act.

Effective date.
42 USC 1382a note.

SEC. 9. (a) The first sentence of section 1613(a) of the Social Security Act is amended—

42 USC 1382b.

(1) by striking out "and" at the end of paragraph (4) thereof,

(2) by striking out the period at the end of paragraph (5) thereof and inserting in lieu of such period the following: "; and", and

(3) by adding after and below paragraph (5) thereof the following new paragraph:

42 USC 1382a.

"(6) assistance referred to in section 1612(b)(11) for the 9-month period beginning on the date such funds are received (or for such longer period as the Secretary shall by regulations prescribe in cases where good cause is shown by the individual concerned for extending such period); and, for purposes of this paragraph, the term 'assistance' includes interest thereon which is excluded from income under section 1612(b)(12).".

Effective date. 42 USC 1382b note.

(b) The amendment made by this section shall be effective July 1, 1976, with respect to catastrophes which occurred on or after June 1, 1976, and before December 31, 1976. With respect to catastrophes which occurred on or after December 1, 1976, the amendment made by this section shall be effective the first day of the calendar quarter following enactment of this Act.

26 USC 3501.

SEC. 10. (a) Chapter 25 of the Internal Revenue Code of 1954 (relating to general provisions for employment taxes) is amended by adding at the end thereof the following new section:

26 USC 3506.

"SEC. 3506. INDIVIDUALS PROVIDING COMPANION SITTING PLACEMENT SERVICES.

"(a) IN GENERAL.—For purposes of this subtitle, a person engaged in the trade or business of putting sitters in touch with individuals who wish to employ them shall not be treated as the employer of such sitters (and such sitters shall not be treated as employees of such person) if such person does not pay or receive the salary or wages of the sitters and is compensated by the sitters or the persons who employ them on a fee basis.

"Sitters."

"(b) DEFINITION.—For purposes of this section, the term 'sitters' means individuals who furnish personal attendance, companionship, or household care services to children or to individuals who are elderly or disabled.

Regulations.

"(c) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the purpose of this section.".

(b) The table of sections for such chapter is amended by adding at the end thereof the following new item:

"Sec. 3506. Individuals providing companion sitting placement services.".

Effective date. 26 USC 3506 note.

(c) The amendments made by this section shall apply to remuneration received after December 31, 1974.

(d) The amendments made by this section shall not be construed as affecting (1) any individual's right to receive unemployment compensation based on services performed before the date of the enactment of this Act, or (2) any individual's eligibility for social security benefits to the extent based on services performed before that date.

SEC. 11. Section 457(c) of the Social Security Act is amended—

42 USC 657.

(a) in paragraph (1)—

(1) by striking out "such support payments" and inserting in lieu thereof "amounts of child support payments which represent monthly support payments", and

(2) by inserting ", which represent monthly support payments," immediately after "amounts so collected", and

(b) in paragraph (2)—

(1) by striking out "such support payments" and inserting in lieu thereof "amounts of child support payments which represent monthly support payments",

(2) by inserting ", which represents monthly support payments," immediately after "amount so collected", and

(3) by striking out the period at the end thereof and inserting in lieu of such period a comma, and

(c) by adding at the end thereof the following new provision: "and so much of any amounts of child support so collected as are in excess of the payments required to be made in paragraph (1) shall be distributed in the manner provided by subsection (b)(3)(A) and (B) with respect to excess amounts described in subsection (b).".

Child support proceeds, distribution.

Approved November 12, 1977.

LEGISLATIVE HISTORY:

HOUSE REPORT No. 95-439 (Comm. on Ways and Means).
SENATE REPORT No. 95-456 (Comm. on Finance).
CONGRESSIONAL RECORD, Vol. 123 (1977):
July 18, considered and passed House.
Oct. 17, considered and passed Senate, amended.
Oct. 25, House concurred in Senate amendment with an amendment.
Oct. 27, Senate concurred in House amendment.

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95TH CONGRESS } HOUSE OF REPRESENTATIVES { REPORT
1st Session } { No. 95-439

CONTINUATION OF EXISTING SUSPENSION OF DUTY ON SYNTHETIC RUTILE

JUNE 16, 1977.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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Mr. ULLMAN, from the Committee on Ways and Means, submitted the following

REPORT

[To accompany H.R. 3387]

The Committee on Ways and Means to whom was referred the bill (H.R. 3387) to continue until the close of June 30, 1980, the existing suspension of duties on synthetic rutile, having considered the same, report favorably thereon with amendments and recommend that the bill as amended do pass.

The amendments (stated in terms of the page and line numbers of the introduced bill) are as follows:

Page 1, line 5, strike out '"June 30, 1977"' and insert '"6/30/77"'.
Page 1, line 6, strike out '"June 30, 1980"' and insert '"6/30/79"'.
Amend the title so as to read:

A bill to continue until the close of June 30, 1979, the existing suspension of duties on synthetic rutile.

DESCRIPTION OF PROVISIONS

H.R. 3387 as reported would amend item 911.25 of the Appendix to the Tariff Schedules of the United States (TSUS) by continuing through June 30, 1979, the existing suspension of duties on synthetic rutile.

The above amendment would take effect after June 30, 1977, the date on which the current duty suspension is due to expire.

GENERAL STATEMENT

Synthetic rutile is derived from ilmenite through a process of upgrading which involves substantial chemical change. Ilmenite, an ore of titanium, contains about 55 percent titanium dioxide. The upgrading process results in a product with a titanium oxide content

Calendar No. 421

No material re social security in this report.

CONSTITUTIONALITY OF [illegible]

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Calendar No. 421

95TH CONGRESS } SENATE { REPORT
1st Session } { No. 95–456

EXTENSION AND WAIVER PROVISIONS RELATED TO SOCIAL SERVICES, MEDICAID, AID TO FAMILIES WITH DEPENDENT CHILDREN PROGRAMS

SEPTEMBER 29 (legislative day, SEPTEMBER 22), 1977.—Ordered to be printed

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Mr. LONG, from the Committee on Finance,
submitted the following

REPORT

[To accompany H.R. 3387]

The Committee on Finance, to which was referred the bill (H.R. 3387) to continue until the close of June 30, 1980, the existing suspension of duties on synthetic rutile, having considered the same, reports favorably thereon with an amendment and an amendment to the title and recommends that the bill as amended do pass.

I. SUMMARY OF PROVISIONS

The bill as passed by the House of Representatives provided for a suspension of tariff duties on synthetic rutile. A similar suspension has already been incorporated by the committee as an amendment to H.R. 2850. The committee amendment strikes the text of the House bill after the enacting clause and substitutes new language relating to certain extensions and waivers of Social Security Act provisions.

The Committee on Finance has under consideration or has reported legislation making several changes in the medicaid, social services, and aid to families with dependent children (AFDC) programs. The committee anticipates that this legislation will be considered by the Senate in the near future. There are, however, a few issues related to these programs which require particularly expeditious action in order to prevent program disruptions or the imposition of sanctions. The committee believes that timely action in these areas can best be achieved if these few issues are dealt with separately rather than in the context of broader legislation. The extensions and waivers recommended in this bill are, in every instance, no more extensive than similar provisions which have already been approved by the House of Representatives in other legislation. In addition, the committee bill clarifies the unemployment compensation status of certain State employees who are employed to provide specialized services for schools.

Social services.—The committee bill would extend to February 1, 1978 certain provisions relating to the title XX social services program which would otherwise expire September 30, 1977. The expiring provisions under present law are:

1. *Additional Child Care Funding.*—$200 million in added social services funding for child care was provided at a 100-percent matching rate for fiscal year 1977.

2. *Use of Added Funding for Employment of Welfare Recipients.*—States were authorized to use part of the added $200 million in child care funding for fiscal year 1977 to directly subsidize the employment of welfare recipients in child care jobs.

3. *Welfare Recipients Tax Credit.*—A credit against income taxes of up to $1,000 (20 percent of wages paid) is available under present law for employers who hire welfare recipients for child care jobs.

4. *Child Care Staffing Standards.*—Federal staffing standards for preschool age children are currently in suspense so long as States continue to meet September 1975 standards. In addition, present law allows waiver of Federal staffing standards for child care facilities which serve only a few children whose care is funded under the title XX program. Present law also allows family day care mothers to not count their own school age children in determining whether they meet the Federal standards for such facilities.

5. *Addicts and Alcoholics.*—Provisions adopted in the 94th Congress permit certain aspects of treatment of addicts and alcoholics to be funded under the title XX social services program even though they do not fully meet restrictions in that program. The same legislation also requires the observance of certain special confidentiality provisions when addicts and alcoholics receive services under title XX.

The above provisions were extended to October 1, 1978 under H.R. 7200 as passed by the House.

Protective and Vendor Payments.—In addition, the committee bill includes a provision in H.R. 7200, as passed by the House, relating to protective and vendor payments under the program of Aid to Families with Dependent Children.

First, in cases in which the State agency made a determination of inability to manage funds, payments could be made in the form of joint checks as a kind of vendor payment. Second, the limit on the number of recipients with respect to whom a State could make such protective or vendor payments would be increased to 20 percent. Third, in addition to the protective and vendor payments which the State or local agency could make subject to the new 20 percent limitation, States would be allowed to make payments to cover the cost of utility services or living accommodations in the form of checks drawn jointly to the order of the recipient and the person furnishing the services or accommodations. The amount of the monthly payment which could be made in the form of joint checks would be limited to 50 percent. There would be no limit on the number of recipients with respect to whom joint checks to pay for housing or utilities could be written. This third provision for joint checks would be limited to 2 years, from October 1, 1977 to October 1, 1979.

In addition to authorizing increased numbers and forms of protective and vendor payments, the bill would provide that Federal matching funds could not be denied to any State for the period between January 1, 1968 and April 1, 1977 (1) because the State exceeded the 10-percent limitation on these payments; (2) because it provided assistance in the form of joint checks; or (3) because it did not comply with other specified conditions.

Nursing Home Patient Evaluation Under Medicaid.—The Department of Health, Education, and Welfare plans to reduce Medicaid payment to 20 States by a total of $250 million in the October–December 1977 quarter because of noncompliance with statutory requirements for independent medical review of medicaid patients. The committee amendment would prevent any reduction in Federal matching payments to States until February 1, 1978 because of any prior noncompliance. This will allow time to act on substantive legislative changes now pending.

Unemployment Compensation for Certain School Personnel.—Public Law 94–566 provided for the coverage under State unemployment compensation program of State and local government employees. Special provisions were included for school employees to assure that they would not ordinarily be eligible for benefits during regular vacation periods. The statute was so drawn, however, that school employees who are employed by a central State agency to provide specialized services to schools—such as music teachers who travel from school to school—would apparently be eligible for unemployment benefits during vacation periods. The committee amendment would correct this situation and provide comparable treatment for such employees with the treatment afforded to those actually employed by individual schools.

II. GENERAL PROVISIONS OF THE BILL

SOCIAL SERVICES—CHILD CARE

(Sections 1 (a), (b), (d), and (e) of the Bill)

Present law.—Among other requirements mandated by the social service program—title XX of the Social Security Act—for child care funded under the Social Security Act are certain minimum staffing standards. The standards are shown in the table below.

Child care center staffing requirements under law and HEW regulation

Age of child	*Maximum number of children per staff member*
Under 6 weeks	1 required by regulation.
6 weeks to 3 years	4 required by regulation.[1]
3 to 4 years	5 required by law.[1]
4 to 6 years	7 required by law.[1]
6 to 9 years	15 maximum number allowed by law (though Secretary of HEW may lower the maximum number of children per staff member, thus increasing the staff required).
10 to 14 years	20 maximum number allowed by law (though Secretary of HEW may lower the maximum number of children per staff member, thus increasing the staff required).

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[1] Public Law 94-401 provides that no penalty for noncompliance may be invoked prior to Oct. 1, 1977.

The above standards were to have become effective as of October 1, 1975, the date when the title XX program went into operation. However, because the imposition of these staffing standards would have increased the cost of operation of the program and because of disagreement as to the appropriateness of these standards, the 94th Congress enacted legislation postponing their implementation on a mandatory basis until October 1, 1977, by which time a major study of their appropriateness was to have been completed by the Department of Health, Education, and Welfare.

Legislation enacted earlier this year—Public Law 95-59—has deferred until April 1, 1978 the date by which the Department must make its report on the appropriateness of the child care staffing standards in permanent law. The Department had requested this deferral in order to permit it to take into account the results of certain studies which would not have been completed in time to be used under the prior deadline of July 1, 1977.

The 94th Congress legislation, in addition to suspending the implementation of the title XX staffing standards for child care, also provided for a temporary increase in the limit on Federal funding under the title XX program. The amount made available was $40 million for the period prior to fiscal year 1977 and $200 million for fiscal year 1977. The additional funding was allocated among the States in the same way as the permanent $2.5 billion limit, that is on a population basis. The $200 million for fiscal year 1977 was available on a 100-percent Federal basis and could not exceed the amount of State expenditures for child care. The law requires States, to the extent they determine feasible, to use the added Federal funding in a way which would increase employment of welfare recipients and other low income persons in child care jobs. The law also permits States, without regard to the usual title XX requirements, to use the added Federal funding to make grants to child care providers to cover the cost of employing welfare recipients. These grants are limited to $4,000 a year per employee in the case of proprietary providers. For public and nonprofit providers, which are ineligible for tax credits, the limit on grants is $5,000. Grants can be made under this authority only if at least 20 percent of the children served by the child care provider have their care paid for through the title XX program.

Committee provision.—The committee bill would provide for temporary extension of the present law provisions to February 1, 1978, by which time the Congress will have had time to consider permanent legislation. The House, as part of H.R. 7200, has approved extension of the provisions to October 1, 1978, with the exception of a funding provision which would provide for a new $2.7 billion ceiling on social services on a permanent basis.

Under the committee bill, the new funding for child care which was authorized under Public Law 94-401 would be extended for the 4-month period October 1977 through January 1978. Thus each State would be entitled to its share of $66.6 million for that period. As under present law, the new funds would be provided foı child care services on a 100-percent Federal funding basis. In addition, under the committee bill the child care standards which have been suspended to October 1, 1977, would be suspended to February 1, 1978.

The committee bill would extent for 4 months the provision due to expire October 1, 1977 to permit State welfare agencies to waive the

Federal staffing requirements in the care of child care centers and group day care homes which meet State standards if the children receiving federally funded care represent no more than 20 percent of the total number of children served—or in the case of a center, there are no more than 5 such children—provided that it is infeasible to place the children in a facility which does meet the Federal requirements. The committee provision would also extend for 4 months the current temporary provision under which, in counting the number of children who may be cared for in a family day care home, the family day care mother's own children are not counted unless they are under age 6.

The legislation enacted in 1976 also included temporary provisions designed to encourage the employment of welfare recipients in child care jobs. The welfare recipient employment incentive tax credit which provides a 20-percent credit for the expenses incurred by employers in hiring welfare recipients was made effective to September 30, 1977, in the case of child care jobs. States were also authorized to use a part of the additional funds available under the social service program to reimburse employers for the costs of hiring welfare recipients to the extent that the costs were not met through the tax credit. The committee bill would extend these two provisions to February 1, 1978. The Committee expects to modify the tax credit provisions when it reports permanent legislation.

ADDICTS AND ALCOHOLICS

(Section 1(c) of the bill)

Present law.—The 94th Congress enacted a temporary amendment to title XX, due to expire September 30, 1977, to require that special confidentiality requirements of the Comprehensive Alcohol Abuse Act be observed with regard to addicts and alcoholics, clarify that the entire rehabilitative process must be considered in determining whether medical services provided to addicts and alcoholics can be funded as an integral part of a State social services program, and provide for funding of a 7-day detoxification period even though social services funding is generally not available for persons in institutions.

Committee provision.—These temporary provisions have proven to be beneficial to the program and the committee amendment would extend them to February 1, 1978, pending permanent legislation.

UNEMPLOYMENT COMPENSATION PROVISION

(Section 2 of the Bill)

Public Law 94–566 required States to cover virtually all State and local government employees under their unemployment compensation programs. Because of the special work patterns of school employees, this legislation required that benefits not be paid during regular vacation periods to teachers who have a reasonable expectation of reemployment at the end of the vacation. Nonprofessional school employees could, at State option, be excluded from benefits during vacation periods on the same basis.

As the statute was drawn, however, these exclusions apply only to individuals who are actually employed by educational institutions. In a number of States there are separate State agencies set up to provide specialized services to many schools. For example, such agencies may provide driver education and audiovisual services to all schools in the State and employees of these agencies may travel from school to school providing these services. Since such employees are in every respect the equivalent of school personnel and follow the same work and vacation patterns, it seems appropriate to apply the same benefit exclusions during vacation periods to these employees as are applied to persons who are directly employed by schools.

The committee bill would extend to such individuals the provisions under which professional employees must be denied benefits during vacation periods (and nonprofessional employees may be denied such benefits) where there is reasonable expectation of reemployment at the end of the vacation.

PROTECTIVE AND VENDOR PAYMENTS

(Section 3 of the Bill)

Present Law.—Under existing law States are allowed to make protective or vendor payments, instead of direct cash payments, with respect to recipients of aid to families with dependent children. The number of recipients with respect to whom such payments may be made in any State may not exceed 10 percent of the number of other ADFC recipients, and the payments may be made only under specified conditions. State plans for such payments must include privisions for: (1) determination by the State agency that the relative of the child with respect to whom the payments are made has such inability to manage funds that making payments to him would be contrary to the welfare of the child; (2) undertaking and continuing special efforts to develop greater ability on the part of the relative to manage funds in such manner as to protect the welfare of the family; and (3) periodic review by the State agency of the determination to make protective or vendor payments to ascertain whether conditions justifying the determination still exist, with provision for termination of the payments if they do not, and for seeking judicial appointment of a guardian or other legal representative if it appears that the need for protective or vendor payments is continuing or is likely to continue beyond a specified period.

Committee provision.—During its hearings on H.R. 7200 the Committee heard persuasive testimony that the provisions of present law frequently act as a barrier to an AFDC family in obtaining adequate housing. It was maintained that by raising the limit on the number of protective and vendor payments which could be made and adding new provisions for joint checks in certain circumstances, recipients would be more likely than at present to get the housing and utility services which they need. The committee bill thus includes several provisions relating to protective and vendor payments. These provisions are identical to provisions of H.R. 7200, as passed by the House. First, in cases in which the State agency made a determination of inability to manage funds, payments could be made in the form of joint checks as a kind of vendor payment. Such joint checks could be made at the discretion of either the State or local agency administering the State plan. A statement of the specific reasons for making the payments in that manner would have to be placed in the case file. Second, the limit on the number of recipients with respect to whom a State could make protective or vendor payments would be increased to 20 percent. Third, in addition to the protective and vendor payments which the State or local agency could make subject to the new 20-percent limitation. States would be allowed to make payments to cover the cost of utility services or living accommodations in the form of checks drawn jointly to the order of the recipient and the person furnishing the services or accommodations. Such joint checks would have to be requested by the recipient in writing, and the request would be effective until revoked by the recipient. The amount of the monthly payment which could be made in the form of joint checks would be limited to 50 percent. These joint checks could be made at the discretion of either the State or local agency administering the State plan, and there would be no limit on the number of recipients with respect to whom joint checks to pay for housing or utilities could be written.

Because of the concern for potential abuse, the committee has limited Federal matching for voluntary, two-party vendor payments to a period of 2 years, or until October 1, 1979. The committee expects the Secretary of HEW to carefully monitor the implementation of this section and to obtain from the States such information as he may need to report to the committee on the experience of the States with the voluntary, two-party vendor arrangement allowed under this section. This report should be made available in time for the information to be used by the committee in considering any legislative action that might be taken prior to the expiration date of these provisions.

In addition to authorizing increased numbers and forms of protective and vendor payments, the committee bill would provide that Federal matching funds could not be denied to any State for the period between January 1, 1968, and April 1, 1977: (1) because the State exceeded the 10-percent limitation on these payments; (2) because it provided assistance in the form of joint checks; or (3) because it did not comply with the State plan provisions described above which limit the conditions under which protective or vendor payments may be made. Testimony was presented at the hearings that without this "forgiveness" provision, New York City might be penalized about two-thirds of $1 billion over an 8¼-year period.

MEDICAID UTILIZATION CONTROL

(Section 1(f) of the Bill)

Present law.—Present law requires that States conduct regular independent professional evaluation of Medicaid patients in skilled nursing and intermediate care facilities and in mental hospitals. Under the 1972 Social Security Amendments, Federal matching payments are to be automatically reduced by one-third for patients who are in skilled nursing homes or intermediate care facilities for more than 60 days. The reduced matching does not occur where a State demonstrates that it is satisfactorily undertaking the required regular independent review of all patients in all facilities.

Committee provision.—The Department of Health, Education, and Welfare plans to reduce medicaid payments to 20 States by a total of $250 million in the October-December 1977 quarter because of noncompliance with statutory requirements for independent medical review of medicaid patients. The committee is encouraged that the Department has begun to aggressively implement the congressional mandate. However, in view of past inaction on the part of HEW, it feels that the sudden reduction in Federal funds for past years activities could have a severe and unanticipated impact on affected State medicaid programs. Further, Congress intended this program to be an incentives program to be validated on a current basis by HEW. The committee amendment would prevent any reduction in Federal matching payments to States until February 1, 1977, because of any prior noncompliance. This will allow time to act on substantive legislative changes now pending.

The States which will be affected by the reductions if this provision is not enacted and the amounts involved are shown below.

Penalties imposed October 1, without legislation

Alabama	$2, 925, 901
Alaska	274, 083
California	30, 718, 446
Colorado	4, 590, 794
Illinois	2, 117, 346
Iowa	6, 241, 218
Kansas	3, 887, 502
Maryland	2, 236, 487
Massachusetts	19, 025, 834
Michigan	9, 196, 973
Minnesota	5, 290, 508
Missouri	2, 947, 502
Montana	737, 379
Nebraska	1, 386, 147
New Jersey	11, 138, 489
New York	107, 612, 304
North Carolina	2, 687, 131
North Dakota	503, 327
Ohio	6, 943, 149
Pennsylvania	13, 593, 459
Tennessee	8, 711, 618
Wisconsin	6, 827, 299
Total	249, 592, 896

III. BUDGETARY IMPACT OF THE BILL

In compliance with section 252(a) of the Legislative Reorganization Act of 1970 and section 308 of the Congressional Budget Act of 1974, the following statements are made relative to the budgetary impact of the bill. This bill is essentially a temporary measure designed to provide certain extensions and waivers pending enactment of permanent legislation. The only provision expected to have a budgetary impact is the extension of the additional funding for child care services. The annual $200 million increase in the limit on social services enacted as part of Public Law 94–401 would be extended for four months. The committee estimates that approximately half of the additional funding available under this authority would actually be used during this period. On this basis it is estimated that the legislation would result in increased Federal expenditures of approximately $33 million in fiscal year 1978. This increase is consistent with (and less than) the allowance for new legislation of this type in the budget allocation report filed by the committee relative to the second concurrent resolution on the budget for fiscal year 1978.

IV. VOTE OF THE COMMITTEE IN REPORTING THE BILL

In compliance with section 133 of the Legislative Reorganization Act of 1946, the following statement is made relative to the vote by the committee to report the bill. The bill was ordered reported by a voice vote.

V. REGULATORY IMPACT

In accordance with paragraph 5 of rule XXIX of the Standing Rules of the Senate, the following statement of the regulatory impact of the bill is made.

The basic purpose of the bill is to extend certain expiring provisions and relieve States from certain fiscal sanctions which would otherwise be imposed. As such, the bill, if anything, would tend to relieve somewhat the regulatory changes which might otherwise be required. One provision dealing with vendor payments under the Aid to Families with Dependent Children program will, if the States choose to use the authority granted thereby, require some additional recordkeeping and compliance with regulations designed to assure proper use of the provision. However, this is entirely voluntary with the States and should have a negligible impact on their overall operation of the program.

VI. CHANGES IN EXISTING LAW

In the opinion of the committee, it is necessary in order to expedite the business of the Senate, to dispense with the requirements of subsection 4 of rule XXIX of the Standing Rules of the Senate (relating to the showing of changes in existing law made by the bill, as reported).

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Finder's Aid

P.L. 95-210 (91 Stat. 1485) Approved December 13, 1977

Subject	SS Act Section	P.L. Section	91 Stat.	H.Rep. 95-548-I	H.Rep. 95-548-II	H.C.Rep. 95-790
Technical Amendment	1832(a)(1)	1(a)	1485	--	--	--
Adds "Rural Health Clinic Services	1832(a)(2)(D)	1(a)(2)	1485	2-3	--	--
Technical Amendment	1833(a)(2)	1(b)(2)	1485	--	--	--
Reimbursement Formula for Rural Health Clinics	1833(a)(3)	1(b)(4)	1485	7-8	--	2, 9
Defines Medicare Coverage of Rural Health Clinics	1861(aa)	1(d)	1485	3-9	6-12	9-13
Adds Rural Health Clinic to Medicare Definition	1861(s)	1(h)	1488	--	--	--
Adds Rural Health Clinic Services to Medicare Definition	1861(s)(2)(E)	1(g)	1487	--	--	--
Exempts Rural Health Clinic Services from Nonreimbursement by Government Entity	1862(a)(3)	1(f)	1487	--	--	--
Use of State Agency for Compliance (Technical Amendment)	1864	1(i)	1488	--	--	--
Technical Amendment	1866(c)(2)	2(e)	1489	--	--	--
Rural Health Clinic--Medicaid--Reasonable Cost	1902(a)(13)(F)	2(c)(1)	1488	--	4-5, 13	--
Technical Amendment	1902(a)(23)	2(c)(2)	1488	--	--	--
Adds Rural Health Clinic Services to Medicaid	1905(a)(2)	2(a)	1488	--	--	12-13
Definition of Terms	1905(1)	2(b)	1488	--	--	12-13
Medicaid Definition Equates with Medicare	1910(b)	2(d)	1489	--	--	--

11

Public Law 95-210
95th Congress

An Act

To amend titles XVIII and XIX of the Social Security Act to provide payment for rural health clinic services, and for other purposes.

Dec. 13, 1977
[H.R. 8422]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Social Security Act, amendments.

MEDICARE AMENDMENTS

SECTION 1. (a) Section 1832(a) of the Social Security Act is amended—

42 USC 1395k.

(1) by striking out "paragraph (2)(B)" in paragraph (1) and inserting in lieu thereof "subparagraphs (B) and (D) of paragraph (2)"; and

(2) by striking out the period at the end of paragraph (2)(C) and inserting in lieu thereof "; and" and by adding the following new subparagraph at the end of paragraph (2):

"(D) rural health clinic services."

(b) Section 1833(a) of such Act is amended—

42 USC 1395*l*.

(1) by striking out "and" at the end of paragraph (1);

(2) by inserting "(except those services described in subparagraph (D) of section 1832(a)(2))" in paragraph (2) after "1832(a)(2)";

Supra.

(3) by striking out the period at the end of paragraph (2) and inserting in lieu thereof ", and"; and

(4) by inserting the following new paragraph after paragraph (2):

"(3) in the case of services described in section 1832(a)(2)(D), 80 percent of costs which are reasonable and related to the cost of furnishing such services or on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under section 1861(v)(1)(A)."

42 USC 1395x.

(c) The Secretary of Health, Education, and Welfare (hereinafter in this Act referred to as the "Secretary") shall conduct a study of the feasibility and desirability of imposing a copayment for each visit to a rural health clinic for rural health clinic services under part B of title XVIII of the Social Security Act, instead of the deductible and coinsurance amounts otherwise required under section 1833 of such Act with respect to the provision of such services. The Secretary shall report to the appropriate committees of Congress, not later than one year after the date of enactment of this Act, on such study and on any recommendations he may have for changes in the provisions of part B of title XVIII of the Social Security Act to reflect the findings of such study.

Study.
42 USC 1395*l* note.
42 USC 1395j.
Supra.
Report to congressional committees.

(d) Section 1861 of such Act is amended by adding at the end thereof the following new subsection:

Definitions.
42 USC 1395x.

"Rural Health Clinic Services

"(aa)(1) The term 'rural health clinic services' means—

"(A) physicians' services and such services and supplies as are covered under section 1861(s)(2)(A) if furnished as an incident to a physician's professional service, "(B) such services furnished by a physician assistant or by a nurse practitioner and such services and supplies furnished as an incident to his service as would otherwise be covered if furnished by a physician or as an incident to a physician's service, and

"(C) in the case of a rural health clinic located in an area in which there exists a shortage of home health agencies, part-time or intermittent nursing care and related medical supplies (other than drugs and biologicals) furnished by a registered professional nurse or licensed practical nurse to a homebound individual under a written plan of treatment (i) established and periodically reviewed by a physician described in paragraph (2)(B), or (ii) established by a nurse practitioner or physician assistant and periodically reviewed and approved by a physician described in paragraph (2)(B),

when furnished to an individual as an outpatient of a rural health clinic.

"(2) The term 'rural health clinic' means a facility which—

"(A) is primarily engaged in furnishing to outpatients services described in subparagraphs (A) and (B) of paragraph (1);

"(B) in the case of a facility which is not a physician-directed clinic, has an arrangement (consistent with the provisions of State and local law relative to the practice, performance, and delivery of health services) with one or more physicians (as defined in subsection (r)(1)) under which provision is made for the periodic review by such physicians of covered services furnished by physician assistants and nurse practitioners, the supervision and guidance by such physicians of physician assistants and nurse practitioners, the preparation by such physicians of such medical orders for care and treatment of clinic patients as may be necessary, and the availability of such physicians for such referral of and consultation for patients as is necessary and for advice and assistance in the management of medical emergencies; and, in the case of a physician-directed clinic, has one or more of its staff physicians perform the activities accomplished through such an arrangement;

"(C) maintains clinical records on all patients;

42 USC 1395cc.

"(D) has arrangements with one or more hospitals, having agreements in effect under section 1866, for the referral and admission of patients requiring inpatient services or such diagnostic or other specialized services as are not available at the clinic;

"(E) has written policies, which are developed with the advice of (and with provision for review of such policies from time to time by) a group of professional personnel, including one or more physicians and one or more physician assistants or nurse practitioners, to govern those services described in paragraph (1) which it furnishes;

"(F) has a physician, physician assistant, or nurse practitioner responsible for the execution of policies described in subparagraph (E) and relating to the provision of the clinic's services;

"(G) directly provides routine diagnostic services, including clinical laboratory services, as prescribed in regulations by the Secretary, and has prompt access to additional diagnostic services from facilities meeting requirements under this title;

"(H) in compliance with State and Federal law, has available for administering to patients of the clinic at least such drugs and biologicals as are determined by the Secretary to be necessary for the treatment of emergency cases (as defined in regulations) and has appropriate procedures or arrangements for storing, administering, and dispensing any drugs and biologicals;

"(I) has appropriate procedures for review of ultilization of clinic services to the extent that the Secretary determines to be necessary and feasible; and

"(J) meets such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are furnished services by the clinic.

For the purposes of this title, such term includes only a facility which (i) is located in an area that is not an urbanized area (as defined by the Bureau of the Census) and that is designated by the Secretary either (I) as an area with a shortage of personal health services under section 1302(7) of the Public Health Service Act or (II) as a health manpower shortage area described in section 332(a)(1)(A) of that Act because of its shortage of primary medical care manpower, (ii) has filed an agreement with the Secretary by which it agrees not to charge any individual or other person for items or services for which such individual is entitled to have payment made under this title, except for the amount of any deductible or coinsurance amount imposed with respect to such items or services (not in excess of the amount customarily charged for such items and services by such clinic), pursuant to subsections (a) and (b) of section 1833, (iii) employs a physician assistant or nurse practitioner, and (iv) is not a rehabilitation agency or a facility which is primarily for the care and treatment of mental diseases. A facility that is in operation and qualifies as a rural health clinic under this title or title XIX and that subsequently fails to satisfy the requirement of clause (i) shall be considered, for purposes of this title and title XIX, as still satisfying the requirement of such clause.

42 USC 300e-1.
42 USC 256.
Ante, p. 1485.
42 USC 1396.

"(3) The term 'physician assistant' and the term 'nurse practitioner' mean, for the purposes of paragraphs (1) and (2), a physician assistant or nurse practitioner who performs such services as such individual is legally authorized to perform (in the State in which the individual performs such services) in accordance with State law (or the State regulatory mechanism provided by State law), and who meets such training, education, and experience requirements (or any combination thereof) as the Secretary may prescribe in regulations.".

(e) Any private, nonprofit health care clinic that—

42 USC 1395x note.

(1) on July 1, 1977, was operating and located in an area which on that date (A) was not an urbanized area (as defined by the Bureau of the Census) and (B) had a supply of physicians insufficient to meet the needs of the area (as determined by the Secretary), and

(2) meets the definition of a rural health clinic under section 1861(aa)(2) or section 1905(l) of the Social Security Act, except for clause (i) of section 1861(aa)(2),

Ante, p. 1485.
Post, p. 1488.

shall be considered, for the purposes of title XVIII or XIX, respectively, of the Social Security Act, as satisfying the definition of a rural health clinic under such section.

42 USC 1395.

(f) Section 1862(a)(3) of such Act is amended by striking out "in such cases" and inserting in lieu thereof "in the case of rural health clinic services, as defined in section 1861(aa)(1), and in such other cases".

42 USC 1395y.
Ante, p. 1485.

(g) Section 1861(s)(2) of such Act is amended—

42 USC 1395x.

(1) by striking out "and" at the end of subparagraph (C)(ii);

(2) by inserting "and" at the end of subparagraph (D); and

(3) by adding the following new subparagraph at the end thereof:

"(E) rural health clinic services;".

42 USC 1395x.

(h) The second sentence of section 1861(s) of such Act is amended by inserting ", a rural health clinic," after "physician's office".

42 USC 1395aa.

(i) Section 1864(a) of such Act is amended—

Ante, p. 1485.

(1) by inserting "or whether a facility therein is a rural health clinic as defined in section 1861(aa) (2)," in the first sentence after "home health agency,";

(2) by inserting "rural health clinic," in the second sentence after "nursing facility,";

(3) by inserting "rural health clinic," in the last sentence after "facility," the first and second times it appears; and

(4) by striking out "such facility" in the last sentence and inserting in lieu thereof "such health care facility, rural health clinic".

Effective date.
42 USC 1395k note.

(j) The amendments made by this section shall apply to services rendered on or after the first day of the third calendar month which begins after the date of enactment of this Act.

MEDICAID AMENDMENTS

42 USC 1396d.

SEC. 2. (a) Paragraph (2) of section 1905(a) of the Social Security Act is amended to read as follows:

"(2)(A) outpatient hospital services, and (B) consistent with State law permitting such services, rural health clinic services (as defined in subsection (l)) and any other ambulatory services which are offered by a rural health clinic (as defined in subsection (l)) and which are otherwise included in the plan;".

"Rural health clinic services" and "rural health clinic."

(b) Section 1905 of such Act is amended by adding after subsection (k) the following new subsection:

"(l) The terms 'rural health clinic services' and 'rural health clinic' have the meanings given such terms in section 1861(aa), except that (1) clause (ii) of section 1861(aa)(2) shall not apply to such terms, and (2) the physician arrangement required under section 1861(aa)(2)(B) shall only apply with respect to rural health clinic services and, with respect to other ambulatory care services, the physician arrangement required shall be only such as may be required under the State plan for those services.".

42 USC 1396a.

(c) Section 1902(a) of such Act is amended—

(1) by striking out the semicolon at the end of paragraph (13) and inserting in lieu thereof "; and", and by adding at the end of such paragraph the following new subparagraph:

"(F) for payment for services described in section 1905(a)(2)(B) provided by a rural health clinic under the plan of 100 percent of costs which are reasonable and related to the cost of furnishing such services or based on such other tests of reasonableness, as the Secretary may prescribe in regulations under section 1833(a)(3), or, in the case of services to which those regulations do not apply, on such tests of reasonableness as the Secretary may prescribe in regulations under this subparagraph;"; and

Ante, p. 1485.

(2) by inserting ", or by reason of the fact that the plan provides for payment for rural health clinic services only if those services are provided by a rural health clinic" before the semicolon at the end of paragraph (23).

(d) Section 1910 of such Act is amended—

42 USC 1396i.

(1) by amending the heading to read as follows: "CERTIFICATION AND APPROVAL OF SKILLED NURSING FACILITIES AND OF RURAL HEALTH CLINICS";

(2) by striking out "(a)" and inserting in lieu thereof "(a)(1)";

(3) by striking out "(b)" and inserting in lieu thereof "(2)"; and

(4) by adding at the end thereof the following new subsection:

Certification.

"(b)(1) Whenever the Secretary certifies a facility in a State to be qualified as a rural health clinic under title XVIII, such facility shall be deemed to meet the standards for certification as a rural health clinic for purposes of providing rural health clinic services under this title.

42 USC 1395.

"(2) The Secretary shall notify the State agency administering the medical assistance plan of his approval or disapproval of any facility in that State which has applied for certification by him as a qualified rural health clinic.".

Approval.

(e) Section 1866(c)(2) of such Act is amended by striking out "section 1910" and inserting in lieu thereof "section 1910(a)".

42 USC 1395cc.

(f)(1) The amendments made by this section shall (except as otherwise provided in paragraph (2)) apply to medical assistance provided, under a State plan approved under title XIX of the Social Security Act, on and after the first day of the first calendar quarter that begins more than six months after the date of enactment of this Act.

Effective date.
42 USC 1395cc note.
42 USC 1396.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act.

DEMONSTRATION PROJECTS FOR PHYSICIAN-DIRECTED CLINICS IN URBAN MEDICALLY UNDERSERVED AREAS

SEC. 3. (a) The Secretary shall provide, through demonstration projects, reimbursement on a cost basis for services provided by physician-directed clinics in urban medically underserved areas for which payment may be made under title XVIII of the Social Security Act and, notwithstanding any other provision of such title, for services provided by a physician assistant or nurse practitioner employed by such clinics which would otherwise be covered under such title if provided by a physician.

42 USC 1395b-1 note.

(b) The demonstration projects developed under subsection (a) shall be of sufficient scope and carried out on a broad enough scale to allow the Secretary to evaluate fully—

Evaluation.

(1) the relative advantages and disadvantages of reimbursement on the basis of costs and fee-for-service for physician-directed clinics employing a physician assistant or nurse practitioner;

(2) the appropriate method of determining the compensation for physician services on a cost basis for the purposes of reimbursement of services provided in such clinics;

(3) the appropriate definition for such clinics;

(4) the appropriate criteria to use for the purposes of designating urban medically underserved areas; and

(5) such other possible changes in the provisions of title XVIII of the Social Security Act as might be appropriate for the efficient and cost-effective reimbursement of services provided in such clinics.

42 USC 1395.

Expenditures.

(c) Grants, payments under contracts, and other expenditures made for demonstration projects under this section shall be made in appropriate part from the Federal Hospital Insurance Trust Fund (established by section 1817 of the Social Security Act) and the Federal Supplementary Medical Insurance Trust Fund (established by section 1841 of the Social Security Act). Grants and payments under contracts may be made either in advance or by way of reimbursement, as may be determined by the Secretary, and shall be made in such installments and on such conditions as the Secretary finds necessary to carry out the purpose of this section. With respect to any such grant, payment, or other expenditure, the amount to be paid from each trust fund shall be determined by the Secretary giving due regard to the purposes of the demonstration projects.

42 USC 1395i.

42 USC 1395t.

Report to Congress.

(d) The Secretary shall submit to the Congress, no later than January 1, 1981, a complete, detailed report on the demonstration projects conducted under subsection (b). Such report shall include any recommendations for legislative changes which the Secretary finds necessary or desirable as a result of carrying out such demonstration projects.

Definitions.

(e) As used in this section, the terms "physician assistant" and "nurse practitioner" have the meanings given such terms in section 1861(aa)(3) of the Social Security Act.

Ante, p. 1485.

REPORT BY THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE ON MENTAL HEALTH AND OTHER CENTERS

42 USC 1395*ll* note.

SEC. 4. (a) The Secretary shall submit to the Congress, no later than six months after the date of enactment of this Act, a report on the advantages and disadvantages of extending coverage under title XVIII of the Social Security Act to urban or rural comprehensive mental health centers and to centers for treatment of alcoholism and drug abuse.

(b) The report submitted under subsection (a) shall include evaluations of—

(1) the need for coverage under such title of services provided by such centers;

(2) the extent of present utilization of such centers by individuals eligible for benefits under such title;

(3) alternatives to services provided by such centers presently available to individuals eligible for benefits under such title;

(4) the appropriate definition for such centers;

(5) the types of treatment provided by such centers;

(6) present Federal and State funding for such centers;

(7) the extent of coverage by private insurance plans for services provided by such centers;

(8) present and projected costs of services provided by such centers;

(9) available methods for assuring proper utilization of such centers;

(10) the effect of allowing coverage for services provided by such centers on other providers and practitioners; and

(11) the need for any demonstration projects for further evaluation of the need for coverage for services provided by such centers.

ACCESS TO CERTAIN TAX RETURN INFORMATION BY THE NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH

SEC. 5. Subsection (m) of section 6103 of the Internal Revenue Code of 1954 (relating to disclosure of taxpayer identity information) is amended to read as follows: 26 USC 6103.

"(m) DISCLOSURE OF TAXPAYER IDENTITY INFORMATION.—

"(1) TAX REFUNDS.—The Secretary may disclose taxpayer identity information to the press and other media for purposes of notifying persons entitled to tax refunds when the Secretary, after reasonable effort and lapse of time, has been unable to locate such persons.

"(2) FEDERAL CLAIMS.—Upon written request, the Secretary may disclose the mailing address of a taxpayer to officers and employees of an agency personally and directly engaged in, and solely for their use in, preparation for any administrative or judicial proceeding (or investigation which may result in such a proceeding) pertaining to the collection or compromise of a Federal claim against such taxpayer in accordance with the provisions of section 3 of the Federal Claims Collection Act of 1966. 31 USC 952.

"(3) NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH.—Upon written request, the Secretary may disclose the mailing address of taxpayers to officers and employees of the National Institute for Occupational Safety and Health solely for the purpose of locating individuals who are, or may have been, exposed to occupational hazards in order to determine the status of their health or to inform them of the possible need for medical care and treatment.".

TRANSFER OF PUBLIC HEALTH SERVICE HOSPITAL IN TEXAS

SEC. 6. If the Secretary acquires the Space Center Memorial Hospital in Nassau Bay, Texas, for the purpose of transferring to it the activities and functions of the Public Health Service hospital in Galveston, Texas, the Secretary may close the Public Health Service hospital in Galveston, Texas.

Approved December 13, 1977.

LEGISLATIVE HISTORY:

HOUSE REPORTS: No. 95-548, pt. II (Comm. on Ways and Means), No. 95-548, pt. II (Comm. on Interstate and Foreign Commerce), and No. 95-790 (Comm. of Conference).

CONGRESSIONAL RECORD, Vol. 123 (1977):
Oct. 17, considered and passed House.
Oct. 19, considered and passed Senate, amended.
Nov. 29, House and Senate agreed to conference report.

WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS, Vol. 13, No. 51:
Dec. 13, Presidential statement.

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95th Congress
1st Session

HOUSE OF REPRESENTATIVES

Report 95–548
Part I

RURAL HEALTH CLINIC SERVICES

REPORT

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ON

H.R. 8422

July 29, 1977.—Ordered to be printed

U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON : 1977

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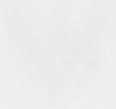

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95TH CONGRESS } HOUSE OF REPRESENTATIVES { REPT. 95-
1st Session } { 548 Part 1

RURAL HEALTH CLINIC SERVICES

JULY 29, 1977.—Ordered to be printed

Mr. ULLMAN, from the Committee on Ways and Means,
submitted the following

REPORT

[To accompany H.R. 8422]

The Committee on Ways and Means, to whom was referred the bill (H.R. 8422) to amend title XVIII of the Social Security Act to provide payment for rural health clinic services, having considered the same, report favorably thereon with amendments and recommend that the bill as amended do pass.

The amendments (stated in terms of the page and line numbers of the introduced bill) are as follows:

On the first page line 7, insert after the semicolon "and".

On the first page, strike out line 8 and all that follows down through line 2 on page 2.

Page 2, line 3, strike out "(3)" and insert in lieu thereof "(2)".

Page 2, line 15, strike out "; and" and insert in lieu thereof ", and".

Page 3, line 13, before "clinic" insert "rural health".

Page 3, line 18, after "(B)" insert the following: "in the case of a facility which is not a physician-directed clinic,".

Page 3, line 21, strike out "section 1861" and insert in lieu thereof "subsection".

Page 4, line 6, strike out "except that" and insert in lieu thereof "and".

Page 4, line 7, strike out "shall have" and insert in lieu thereof "has".

Page 6, line 19, strike out "clinics," and insert in lieu thereof "clinic services,".

Page 6, strike out line 21 and all that follows down through line 9 on page 7, and insert in lieu thereof the following:

> (e) Section 1861(s)(2) of such Act is amended—
>
> (1) by striking out "and" at the end of subparagraph (C)(ii);
>
> (2) by inserting "and" at the end of subparagraph (D); and
>
> (3) by adding the following new subparagraph at the end thereof:
>
> "(E) rural health clinic services;".

Page 8, line 3, strike out "physician extenders" and insert "primary care practitioners".

Page 8, beginning in line 11, strike out "physician extenders" and insert "primary care practitioner".

Page 9, line 10, strike out "grant" and insert in lieu thereof "grant,".

Page 9, line 16, strike out "project" and insert in lieu thereof "projects".

Page 9, line 19, strike out "project" and insert in lieu thereof "projects".

Page 10, line 8, strike out "(i)" and insert in lieu thereof "(A)".

Page 10, line 11, strike out "(ii)" and insert in lieu thereof "(B)".

Page 11, line 20, strike out "experiment or".

Page 11, line 25, strike out "experiment or".

Amend the title so as to read:

> A bill to amend title XVIII of the Social Security Act to provide payment for rural health clinic services, and for other purposes.

I. PURPOSE AND BACKGROUND OF THE BILL

As a result of hearings conducted in Appalachia by your committee's Subcommittee on Health, it has become evident that often the only types of primary and emergency care services available to residents of isolated rural areas are not covered under the medicare program. Because of the inability to support the practice of a physician, these communities have developed clinics where many of the primary care services traditionally performed by physicians are furnished by specially trained nonphysician personnel called primary care practitioners. Under present law, medicare coverage is available for these types of services only when they are provided by a physician.

In recommending legislation to provide medicare coverage for services furnished in these clinics, your committee is attempting to address the severe problem resulting from the lack of physicians in many rural areas. Your committee believes that by providing for reimbursement on the basis of costs incurred in furnishing covered services and by limiting eligibility to clinics located in areas of physician scarcity, the bill addresses the existing problem in a cost-effective and efficient manner.

II. SUMMARY OF THE BILL

As reported, H.R. 8422, provides coverage under part B of medicare for rural health clinic services and requires the Secretary to conduct demonstration projects involving clinics located in medically underserved urban areas and comprehensive outpatient mental health centers. The summary presented below briefly outlines the principal features of the bill.

RURAL HEALTH CLINIC SERVICES

Your committee's bill provides coverage for services furnished by clinics located in rural, medically underserved areas if they are staffed by primary care practitioners. Payment for covered services, including physician services provided in the clinic, would be made directly to the clinic and would be based on the costs incurred in furnishing these services to medicare beneficiaries. Services furnished by primary care practitioners would also be covered if such services are otherwise covered under the medicare program when furnished by a physician and if they are rendered by the primary care practitioner under the general supervision of a physician.

DEMONSTRATION PROJECT FOR URBAN PHYSICIAN-DIRECTED CLINICS

The bill requires the Secretary to develop and carry out demonstration projects to evaluate reimbursement on a cost basis for services provided by physician-directed clinics in urban medically underserved areas. The services to be included in these projects are those which are presently covered under the medicare program and any services provided by primary care practitioners employed by such clinics which would otherwise be covered if provided by a physician. The Secretary is to report to the Congress, no later than January 1, 1981, on the results of these projects with any recommendations for legislative changes which he finds necessary or desirable.

DEMONSTRATION PROJECT FOR COMPREHENSIVE OUTPATIENT MENTAL HEALTH CENTERS

The bill requires the Secretary to develop and carry out demonstration projects to evaluate the effects and implications of medicare reimbursement for services furnished in organized centers offering comprehensive outpatient mental health services. The Secretary is to report to the Congress, no later than January 1, 1981, on the results of these projects with any recommendations for legislative changes which he finds necessary or desirable.

III. General Statement

A. RURAL HEALTH CLINICS

Many isolated rural communities which have not been able to attract or retain a physician have come to rely on clinics which do not follow the traditional model of physician delivery of medical services. These rural clinics are staffed, not by physicians, but by specially trained nurse practitioners and physician assistants—often referred to as primary care practitioners—who are trained to provide primary medical care services traditionally performed only by physicians. Although there is physician supervision of the services provided by primary care practitioners, it is indirect rather than "over the shoulder."

Other, more populated communities that could financially support the practice of a physician, have also had difficulty in retaining physicians. Physicians have often been reluctant to locate in these communities because of the likelihood of a heavy patient load with no relief available for time off for vacation or continuing education. The development of clinics which have a full-time physician but use a primary care practitioner to take responsibility for a large part of the physician's patient load, has meant that many of these communities are now able to retain a physician.

These rural health clinics staffed by primary care practitioners have developed in a variety of ways. Many were developed through public efforts including community fundraising, State and local government funding, and Federal funding under the Office of Economic Opportunity, the Public Health Service, or the Appalachian Regional Commission. In some cases, physicians in private practice in a nearby urban area have set up a "satellite clinic" in a rural area which is staffed by a primary care practitioner.

Although the services provided by the physician, whether he is present in the clinic on a full- or part-time basis are presently covered, the services provided by the primary care practitioner in the rural health clinics are not eligible for any medicare reimbursement.

Under the original medicare act, services of physicians practicing in a clinic setting are covered under part B of medicare. Services provided in the clinic by personnel other than physicians and certain medical supplies are also covered when provided "as an incident to a physician's service."

Over the years, this "incident to" requirement has been interpreted to mean that two requirements must be met. The first is that there must be direct physician supervision of the services provided by the nonphysician personnel. The second is that the services provided by the nonphysician personnel cannot be physician-type services, that is, they cannot be actual medical services.

Primary care practitioners, whether they practice in clinics where there is a physician present full-time or in clinics where only the backup services of a physician are available, meet neither of these requirements. The services they provide are medical care services of the type ordinarily performed only by physicians and the physician supervision of the services is only indirect.

Since the services provided by the primary care practitioner to medicare beneficiaries are not eligible for medicare reimbursement, these services, have either been paid for out-of-pocket by the beneficiary, supported through a grant, or treated by the clinic as a bad debt. As a result of these and other factors, several rural health clinics are now confronted with serious financial problems. Exacerbating the current situation is the fact that Appalachian Regional Commission grants which have been supporting these clinics are due to expire over the next several months. Your committee is concerned that, without medicare funding, many of these clinics can never become self-sufficient and may be forced to close.

Rural health clinic services

Your committee's bill provides coverage for services furnished by primary care practitioners in rural health clinics, whether or not the clinic is under the full-time direction of a physician, provided the primary care practitioner is legally authorized under State law to perform such services. Services and supplies which are furnished incident to a primary care practitioner's services in the clinic would also be covered if they are presently covered when provided as an incident to a physician's service—for example, bandages and traditional nursing services.

Although clinics often provide a wider range of services, for example, drugs, dental services, preventive services, and transportation, these services would not be covered since they are not covered by medicare under any other circumstances.

Rural health clinic

Rural health clinics are defined as those clinics which are located in rural areas that have been designated by the Secretary as having medically underserved populations under section 1302(7) of the Public Health Service Act. Only those clinics which employ a primary care practitioner would be eligible.

Clinical records

Your committee's bill requires that the rural health clinic maintain medical records on all patients. Such a requirement parallels the requirement that hospitals, nursing homes, and home health agencies participating in medicare maintain clinical records on all patients.

Hospital arrangements

Since the clinics serve as an entry point into the medical care system, the bill requires that the clinic have an arrangement with one or more hospitals, meeting requirements of the medicare program, for referral and admission of patients who need inpatient hospital services or other specialized services not available at the clinic.

In order to help assure the quality of the services for which medicare payment is made, the bill requires rural clinics to meet certain criteria as a condition for payment. Since the clinics are of diverse character, these criteria are very broad and flexible. For example, some clinics have been able to obtain relatively sophisticated facilities and equipment while others, although providing quality care, have only the most basic facilities and equipment. There are, however, a number of standards which your committee believes should be met by all covered rural clinics.

Physician supervision arrangement

Although primary care practitioners, particularly nurse practitioners, provide a broad range of services such as health education, preventive care, and counseling, the types of services covered under the medicare program are services which are necessary for the diagnosis and treatment of illness or injury. Since the services covered under this legislation would involve the practice of medicine, the clinic would be required to have an arrangement with a physician under which the physician periodically reviews the services provided by the primary care practitioner, provides supervision and guidance of the primary care and treatment of patients. Under such an arrangement, the physician would be required to make himself available for any necessary referral of patients and for advice and assistance in medical emergencies. However, it would not be necessary for the physician to be physically present when the primary care practitioner provides the services.

In the case of clinics where there is a physician present on a full-time basis the physician services required under the physician arrangement would be provided by one or more of the physicians on the staff of the clinic.

Governing policies

Your committee's bill requires that policies to govern the provision of covered services be developed with the advice of a group of professional personnel, including one or more physicians and one or more primary care practitioners. (Such policies would have to be periodically reviewed.) A physician or primary care practitioner must be designated as responsible for the execution of these policies.

Diagnostic services

Clinics would be required to provide routine diagnostic services, including routine clinical laboratory services, as prescribed in regulations by the Secretary. and to have arrangements for prompt access to additional diagnostic services from facilities meeting medicare requirments. It is not your committee's intent that the clinics be required to provide a broad range of lab services; rather, only those tests which must be immediately available because of the nature of the problem under investigation would be required.

Drugs and biologicals

Your committee's bill requires that the clinic have available for administering at least such drugs and biologicals as are needed in medical emergencies and have appropriate procedures or arrangements for storing, administering, and dispensing all drugs and biologicals.

Health and safety standards

Your committee's bill authorizes the Secretary to require clinics to meet such other standards as he finds necessary for the health and safety of patients. In developing standards to assure the health and safety of patients, the Secretary would be expected to take in account the need for flexibility in standards for the physical facilities. Those standards which would be most important in the type of clinic setting covered under this bill would be those pertaining to fire safety, flood protection and accessibility to the handicapped.

Primary care practitioner

Your committee's bill requires the Secretary to determine what specific education, training, and experience requirements—or any combination thereof—primary care practitioners must meet. In establishing these requirements your committee expects the Secretary to take into account the qualifications necessary to provide primary and emergency care services with the degree of independence from direct physician supervision permitted under the bill. This provision reflects the fact that, because of the diversity of their education and training and the variations in State laws, not all those who may be considered primary care practitioners may be sufficiently qualified to provide services in a remote rural health clinic setting.

The primary care practitioner working in an isolated clinic setting must be capable of performing a broad range of primary care services competently and without the immediate supervision of a physician. In common usage, however, the term "primary care practitioner" is generic and includes individuals with varying ranges of skills. An individual known as a primary care practitioner could be someone who is capable only of performing a limited number of tasks under the close supervision of a physician or someone who is able to exercise judgment in diagnosing and treating primary care needs with only the general supervision of a physician.

There is also considerable variation in the definition of and regulations for primary care practitioners under State law. Some States have specifically defined in law and regulations the scope and type of medical tasks physician assistants and nurse practitioners may perform; the degree of physician supervision required; and the training, education, and experience requirements necessary for performing such tasks. Other States have statutes which allow physicians to delegate medical tasks to "trained assistants" or others without provision for any qualifications of such individuals, restriction on tasks delegated, or reference to the degree of physician supervision required. In some States, there is no legal recognition of the primary care practitioner and State law specifically limits performance of medical care services to physicians. Your committee believes, therefore, that it is essential for the Secretary to assure that appropriate personnel requirements are applied.

Reimbursement for rural health clinic services

Your committee's bill would provide for payment to rural clinics on the basis of costs which are reasonable and related to those costs incurred by the clinics in furnishing covered services to medicare beneficiaries. These costs would include reasonable compensation for the services of primary care practitioners and any physician present on a full-time basis; the cost of services or supplies provided as an incident to the primary care practitioner's service or the physician's service; and overhead costs related to providing the covered services. For those clinics which are not physician-directed—that is, do not have a full-time physician—the reimbursable costs would include the cost incurred by the clinic in securing the required supervisory services of a physician and the cost of any patient care services provided by a physician at the clinic on a part-time basis. Where a physician furnishes services at a clinic on a part- or full-time basis, all services furnished to clinic patients by the physician, including the services he furnished to clinic patients transferred to a hospital, would be reimbursed on a cost basis.

Your committee has developed this provision so as to allow the Secretary maximum flexibility in determining the most efficient reimbursement method given the unique nature of these clinics. Since these clinics are generally very small—perhaps employing as few as three individuals—and use relatively unsophisticated accounting methods, it would impose an undue hardship to mandate the same extensive cost reporting requirements imposed on hospitals and other health care facilities participating in the medicare program. The bill allows the Secretary the options of developing a simple reimbursement mechanism based on the actual costs which are incurred by the clinic; using a prospective method of reimbursement such as all-inclusive rate per visit, which is related to cost; or using any other method that is determined to be reasonable and equitable in this situation.

In determining the reasonableness of costs incurred by clinics, your committee expects the Secretary to establish guidelines to identify situations where costs would not be allowed without further investigation or reasonable justification by the clinic. The various elements of cost which could be used for the development of such screens include: the number of primary care practitioners per supervising physician; patient-staff ratios; percentage of administrative costs to total costs; minimum budgeted capacity; minimum physician/primary care practitioner productivity; and other elements the Secretary deems to be appropriate.

The actual payment to the clinic would be for 80 percent of the cost or rate the Secretary determines is reasonable. This reflects the fact that the services are covered under the supplementary medical insurance part of the medicare program and as such are subject to the part B coinsurance and deductible. Clinics would be required to agree not to charge medicare beneficiaries for services covered by medicare except for the amount of the applicable deductible and coinsurance. The coinsurance and deductible amount would be based on a charge which does not exceed the customary charge of the clinic made for the particular service furnished.

B. DEMONSTRATION PROJECTS FOR PHYSICIAN-DIRECTED CLINICS EMPLOYING PRIMARY CARE PRACTITIONERS IN MEDICALLY UNDERSERVED URBAN AREAS

Although there has been considerable interest in the possibility of providing medicare reimbursement on a cost-related basis for services—including services of primary care practitioners—furnished by clinics located in medically underserved urban areas, your committee was concerned that the effects of providing such reimbursement have not yet been sufficiently examined. For example, it was felt that there would be a substantially greater cost to the medicare program involved in covering urban clinics, since their budgets are several times larger than those of rural clinics. Your committee was also concerned about the potential for uncontrolled proliferation of such clinics in urban areas and the resulting possible abuse of program funds.

Your committee, therefore, felt it was more appropriate to provide cost-related reimbursement for services furnished in urban clinics employing primary care practitioners only on a demonstration basis so as to allow the Secretary to evaluate fully the impact of such reimbursement and recommend any further refinements in the legislative approach to the reimbursement of such clinics. It is your committee's intent that the demonstration be conducted on a broad scale and include a variety of urban in which providing primary care services are provided.

The bill requires the Secretary to specifically evaluate:

(1) the relative advantages and disadvantages of reimbursement on the basis of costs and fee-for-service for physician-directed clinics employing primary care practitioners;

(2) the appropriate method of determining the compensation for physician services on a cost basis;

(3) the appropriate definition for such clinics;

(4) the appropriate criteria for the designation of urban and rural medically underserved areas;

(5) any other changes as might be appropriate for the efficient and cost-effective reimbursement of services provided in such clinics.

The bill requires that the Secretary to report to the Congress with his findings and any legislative recommendations no later than January 1, 1981.

C. DEMONSTRATION PROJECTS FOR COMPREHENSIVE OUTPATIENT MENTAL HEALTH CENTERS

Your committee's bill directs the Secretary to carry out demonstration projects to determine the feasibility of providing more comprehensive coverage under the medicare program for services provided by outpatient mental health centers.

Your committee recognizes that, since 1963, the Federal Government has been involved in efforts to develop centers which offer a broad range of outpatient mental health services in the hope that the availability of such services would replace large institutions as the primary place of treatment of the mentally ill. Your committee supports the concept of providing mental health services on an outpatient basis wherever possible. Your committee is also concerned about the great need for mental health services among the elderly. Although coverage for mental health services is available under the medicare program, there are limitations on the types of services covered, the dollar amounts of services covered, and the types of facilities eligible to provide the covered services.

Although your committee recognizes the positive aspects of expanding coverage of mental health services provided by outpatient centers, it also has a deep concern about the potential problems involved in effectively controlling the utilization and the resulting cost of expanding present coverage for services.

Your committee believes, therefore, that broad-scale demonstration projects should be developed for the reimbursement of outpatient mental health services in order to evaluate among other things, the advantages of reimbursement on a cost basis for such services; whether a change in the medicare coverage provisions would result in more economical and effective utilization of such services; the appropriate definition for such a center; and the appropriate qualifications for individuals who provide covered services in such a center and their appropriate professional interrelationships.

Although a definition for a comprehensive mental health center is presently provided in the Federal Community Mental Health Centers Act, your committee expects that the centers participating in the demonstration projects will represent a variety of settings which offer comprehensive services but which may not offer all of the services required of the federally funded centers.

The bill requires the Secretary to report his findings and any recommendations for legislative changes to the Congress no later than January 1, 1981.

IV. COST OF CARRYING OUT THE BILL AND EFFECT ON THE REVENUES

In compliance with clause 7 of rule XIII of the Rules of the House of Representatives, your committee states that the Social Security Administration's Office of the Actuary (Department of Health, Education, and Welfare) has supplied the committee with the following reason of such individual's membership in a prepayment plan or otherwise) has a legal obligation to provide or pay for;

(3) which are paid for directly or indirectly by a governmental entity (other than under this Act and other than under a health benefits or insurance plan established for employees of such an entity), except [in such cases] *in the case of rural health clinic services, as defined in section 1861(aa)(2), and in other cases* as the Secretary may specify;

(4) which are not provided within the United States (except for inpatient hospital services furnished outside the United States under the conditions described in section 1814(f) and, subject to such conditions, limitations, and requirements as are provided under or pursuant to this title, physicians' services and ambulance services furnished an individual in conjunction with such inpatient hospital services but only for the period during which such inpatient hospital services were furnished);

(5) which are required as a result of war, or of an act of war, occurring after the effective date of such individual's current coverage under such part;

(6) which constitute personal comfort items;

(7) where such expenses are for routine physical checkups, eyeglasses or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, procedures performed (during the course of any eye examination) to determine the refractive state of the eyes, hearing aids or examinations therefor, or immunizations;

(8) where such expenses are for orthopedic shoes or other supportive devices for the feet;

(9) where such expenses are for custodial care;

USE OF STATE AGENCIES TO DETERMINE COMPLIANCE BY PROVIDERS OF SERVICES WITH CONDITIONS OF PARTICIPATION

SEC. 1864. (a) The Secretary shall make an agreement with any State which is able and willing to do so under which the services of the State health agency or other appropriate State agency (or the appropriate local agencies) will be utilized by him for the purpose of determining whether an institution therein is a hospital or skilled nursing facility, or whether an agency therein is a home health agency, *or whether a facility therein is a rural health clinic as defined in section 1861 (aa)(2);* or whether a laboratory meets the requirements of paragraphs (10) and (11) of section 1861(s), or whether a clinic, rehabilitation agency of public health agency meets the requirements of subparagraph (A) or (B), as the case may be, of section 1861 (p)(4). To the extent that the Secretary finds it appropriate, an institution or agency which such a State (or local) agency certifies is a hospital, skilled nursing facility, *rural health clinic*, or home health agency (as those terms are defined in section 1861) may be treated as such by the Secretary. Any State agency which has such an agreement may (subject to approval of the Secretary) furnish to a skilled nursing facility after proper request by such facility, such specialized consultative services (which such agency is able and willing to furnish in a manner satisfactory to the Secretary) as such facility may need to meet one or more of the conditions specified in section 1861(j). Any such services furnished by a State agency shall be deemed to have been furnished pursuant to such agreement. Within 90 days following the completion of each survey of any health care facility, *rural health clinic*, laboratory, clinic, agency, or organization by the appropriate State or local agency described in the first sentence of this subsection, the Secretary shall make public in readily available form and place the pertinent findings of each such survey relating to the compliance of each such health care facility, *rural health clinic*, laboratory, clinic, agency, or organization with (1) the statutory conditions of participation imposed under this title and (2) the major additional conditions which the Secretary finds necessary in the interest of health and safety of individuals who are furnished care or services by any such facility, *rural health clinic*, laboratory, clinic, agency, or organization.

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95TH CONGRESS } HOUSE OF REPRESENTATIVES { REPT. No. 95-548
1st Session } { Part II

RURAL HEALTH CLINIC SERVICES

REPORT

BY THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

[To accompany H.R. 8422]

[Including the Congressional Budget Office Cost Estimate]

SEPTEMBER 19, 1977.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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95TH CONGRESS } HOUSE OF REPRESENTATIVES { REPT. 95-548
1st Session } { Part II

RURAL HEALTH CLINIC SERVICES

SEPTEMBER 19, 1977.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. STAGGERS, from the Committee on Interstate and Foreign Commerce, submitted the following

REPORT

[Including Cost Estimate of the Congressional Budget Office]

[To accompany H.R. 8422]

The Committee on Interstate and Foreign Commerce, to whom was referred the bill (H.R. 8422) to amend title XVIII of the Social Security Act to provide payment for rural health clinic services, having considered the same, report favorably thereon with amendments and recommend that the bill as amended do pass.

The amendments (stated in terms of the page and line numbers of the bill as amended by the Committee on Ways and Means and as reported by the Committee on Interstate and Foreign Commerce) are as follows:

1. Page 3, beginning on line 16, strike out "primary care practitioner" and insert in lieu thereof "physician assistant or by a nurse practitioner".

Page 4, lines 10 through 13, strike out "primary care practitioners" each time it occurs and insert in lieu thereof "physician assistants and nurse practitioners".

Page 5, beginning on line 7, strike out "primary care practitioners" and insert in lieu thereof "physician assistants or nurse practitioners".

Page 5, beginning on line 11, strike out "or primary care practitioner," and insert in lieu thereof ", physician assistant, or nurse practitioner".

Page 6, line 22, strike out "primary care practitioner" and insert in lieu thereof "physician assistant or nurse practitioner".

Page 7, beginning on line 7, strike out " 'primary care practitioner' " and all that follows through "such services as he" on line 9 and insert in lieu thereof " 'physician assistant' and the term 'nurse practitioner' mean, for purposes of paragraphs (1) and (2), a physician assistant, nurse practitioner, or any similar practitioner who performs such services as such individual".

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(vi) persons essential (as described in the second sentence of this subsection) to individuals receiving aid or assistance under State plans approved under title I, X, XIV, or XVI, or

(vii) blind or disabled as defined in section 1614, with respect to States not eligible to participate in the State plan program established under title XVI,

but whose income and resources are insufficient to meet all of such cost—

(1) inpatient hospital services (other than services in an institution for tuberculosis or mental diseases);

~~(2) outpatient hospital services;~~

(2)(A) outpatient hospital services and (B) consistent with State law permitting such services, rural health clinic services (as defined in subsection (l)) and any other ambulatory services which are offered by a rural health clinic (as defined in subsection (l)) and which are otherwise included in the plan;

* * * * * * *

(k) Increased supplemental security income benefits payable pursuant to section 211 of Public Law 93-66 shall not be considered supplemental security income benefits payable under title XVI.

(l) The terms "rural health clinic services" and "rural health clinic" have the meanings given such terms in section 1861(aa), except that clause (ii) of section 1861(aa)(2) shall not apply to such terms.

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CERTIFICATION AND APPROVAL OF SKILLED NURSING FACILITIES **AND OF RURAL HEALTH CLINICS**

SEC. 1910. (a) **(1)** Whenever the Secretary certifies an institution in a State to be qualified as a skilled nursing facility under title XVIII, such institution shall be deemed to meet the standards for certification as a skilled nursing facility for purposes of section 1902(a)(28).

~~(b)~~ **(2)** The Secretary shall notify the State agency administering the medical assistance plan of his approval or disapproval of any institution which has applied for certification by him as a qualified skilled nursing facility.

(b)(1) Whenever the Secretary certifies a facility in a State to be qualified as a rural health clinic under title XVIII, such facility shall be deemed to meet the standards for certification as a rural health clinic for purposes of providing rural health clinic services under this title.

(2) The Secretary shall notify the State agency administering the medical assistance plan of his approval or disapproval of any facility in that State which has applied for certification by him as a qualified rural health clinic.

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Strike out the amendment to the title proposed by the Committee on Ways and Means and insert in lieu thereof the following:

Amend the title so as to read: "A bill to amend titles XVIII and XIX of the Social Security Act to provide payment for rural health clinic services, and for other purposes.".

SUMMARY OF THE BILL AND COMMITTEE AMENDMENTS

As reported by the Committee on Ways and Means, H.R. 8422 would:

(1) Provide coverage under part B of medicare for rural health clinic services furnished by clinics located in rural, medically underserved areas if they are staffed by primary care practitioners. Payment for covered services, including physician services provided in the clinic, would be made directly to the clinic and would be based on the costs incurred in furnishing these services to medicare beneficiaries. Services furnished by primary care practitioners would also be covered if such services are otherwise covered under the medicare program when furnished by a physician and if they are rendered by the primary care practitioner under the general supervision of a physician.

(2) Require the Secretary to develop and carry out demonstration projects to evaluate reimbursement on a cost basis for services provided by physician-directed clinics in urban medically underserved areas. The services to be included in these projects are those which are presently covered under the medicare program and any services provided by primary care practitioners employed by such clinics which would otherwise be covered if provided by a physician. The Secretary is to report to the Congress, no later than January 1, 1981, on the results of these projects with any recommendations for legislative changes which he finds necessary or desirable.

(3) Require the Secretary to develop and carry out demonstration projects to evaluate the effects and implications of medicare reimbursement for services furnished in organized centers offering comprehensive outpatient mental health services. The Secretary is to report to the Congress, no later than January 1, 1981, on the results of these projects with any recommendations for legislative changes which he finds necessary or desirable.

Following hearings and executive sessions, the Committee on Interstate and Foreign Commerce recommends passage of the proposal with the amendments summarized below:

> (1) Requires the State medicaid plan of all States which authorize the medical practice of nurse practitioners and physician assistants to reimburse the services of a rural health clinic;
>
> (2) Authorizes reimbursement for services in clinics located in any rural area designated by the Secretary as a "health manpower shortage area" in addition to the Ways and Means Committee provision which authorizes reimbursement for clinics in rural areas designated as having "medically underserved populations";
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> (3) Includes as eligibles for reimbursement under medicare and medicaid services in clinics which, as of July 1, 1977, (a) employed physician assistants or nurse practitioners, (b) had a patient population of no more than 3,000 ,and (c) had no physician practicing within five miles of the clinic;

(4) Authorizes reimbursement of the services of "nurse practitioners" and "physician assistants" in lieu of the "primary care practitioner" description of such persons in the Ways and Means bill;

(5) Provides that a clinic in an area that loses its designation as a health manpower shortage area or as an area with a shortage of personal health services would nevertheless remain certified for 5 years;

(6) Deletes the requirement that urban demonstration projects be "physician-directed", thus authorizing participation in the program by clinics with part-time physician coverage; and

(7) Authorizes the transfer of the Public Health Service hospital in Galveston, Tex. to the Space Center Memorial Hospital in Nassau Bay, Tex.

LEGISLATIVE BACKGROUND

Legislation to amend title XVIII of the Social Security Act to provide payment for rural clinic services, H.R. 8422, was reported by the Committee on Ways and Means on July 29, 1977, and referred to the Committee on Interstate and Foreign Commerce for its consideration for a period ending not later than September 19, 1977.

Similar legislation, H.R. 8543, which included amendments to title XIX of the Social Security Act, was introduced by Mr. Rogers, chairman of the Subcommittee on Health and the Environment, and eight members of the subcommittee, on July 26, 1977, as a vehicle for hearings. Hearings were conducted on H.R. 8543 and all similar or identical measures on July 29, 1977. H.R. 8422 was subsequently considered in open executive session by the Subcommittee on Health and the Environment, amended, and reported to the Committee on Interstate and Foreign Commerce on September 7, 1977. H.R. 8422, as amended, was considered, amended, and ordered reported by voice vote of the committee on September 13, 1977.

COST OF LEGISLATION

The committee has no basis on which to challenge the cost estimate prepared by the Congressional Budget Office which appears elsewhere in this report.

PURPOSE AND BACKGROUND

The purpose and background of the proposed legislation with respect to title XVIII of the Social Security Act (the medicare program) are explained in Part I of this report.

In part I, the Committee on Ways and Means determined that services provided by specially trained nonphysician personnel in isolated rural areas should be reimbursed under the medicare program in order to support clinics where many of the primary care services traditionally performed by physicians are furnished by such primary care personnel.

This committee wholeheartedly concurs in the findings of the Ways and Means Committee and believes that coverage for appropriate services provided in rural clinics should also be paid for under title XIX of the Social Security Act (the medicaid program). Under existing law, the Federal Government will match the expenditures of States for reimbursement of services of nurse practitioners or physician assistants; however, this committee has determined that approximately two-thirds of State medicaid plans do not authorize reimbursement for the services of such personnel. Because many rural areas are served by clinics which utilize nurse practitioners and physician assistants, as well as physicians, this reimbursement policy clearly does not enable medicaid recipients to gain adequate financial access to those services.

In recommending legislation to provide medicare and medicaid coverage for services furnished in these clinics, the committee believes that it is addressing a problem of financial vitality of existing clinics—and contributing to the attractiveness of establishing new rural clinics—thus better assuring the provision of quality medical care in rural areas served by those clinics. The committee believes that by providing for reimbursement on the basis of costs incurred in furnishing covered services and by limiting eligibility to clinics located in areas of physician scarcity, the bill addresses the existing problem of lack of full-time physician services in such areas in a cost effective and efficient manner.

Committee Proposal

The committee concurs that H.R. 8422, as reported by the Ways and Means Committee, appropriately addresses a health problem of millions of rural residents. Many of these residents live in small, often isolated communities which have been unable to retain or attract a physician. Other rural residents in larger communities with sufficient populations to financially support the practice of physicians have also had difficulty in retaining their physicians. By reimbursing the services of the clinics which now provide health care to many of these communities through physicians, nurse practitioners, physician assistants, and other lawful providers, H.R. 8422 will help to insure that the residents of those rural communities have access to quality health care.

The committee believes that several amendments to H.R. 8422, as reported by the Ways and Means Committee, are warranted. The format of this section follows the format in section III, part I.

Rural health clinic services

H.R. 8422, as reported by the Ways and Means Committee, defines rural health clinic services to include those physician services and those services furnished as an incident to a physician's services, which are presently covered under medicare and those services furnished by a nurse practitioner or physician assistant which would otherwise be covered if furnished by a physician or as an incident to a physician's service. This committee notes that this bill does not expand the services for which medicare will reimburse but that it authorizes reimbursement to these clinics when nurse practitioners and physician assistants provide services (in accordance with State law) for which physicians are now reimbursed. This committee supports this change in medicare coverage and amends the bill to require comparable coverage under medicaid.

The committee's amendment requires a State medicaid plan to reimburse the services of a rural health clinic. Those services include rural health clinic services, as defined for medicare reimbursement, and any other ambulatory services which are offered by the clinic and otherwise included in the State medicaid plan. This expansion of reimbursable providers in State medicaid plans is mandatory for all

States which authorize the medical practice of nurse practitioners and physician assistants. Other States would be required to include the services of a rural health clinic in their medicaid plan if they alter their law to authorize medical practice by nurse practitioners and physician assistants. Other States would be reqnuired to include the services of a rural health clinic in their medicaid plan if they alter their law to authorize medical practice by nurse practitioners and physician assistants.

The committee recognizes that State medicaid plans cover a broader range of services than medicare. To insure that medicaid patients of a rural health clinic have access to all medicaid covered services, the committee has authorized the clinic to provide all ambulatory services included in the State plan. The other ambulatory services which a clinic is likely to provide include family planning; early periodic screening, diagnosis and treatment; drugs; dental services; home health care services; and transportation.

It is the intent of the committee that the clinic be reimbursed under medicare and medicaid when services are furnished to a clinic patient by the clinic's physician, nurse practitioner or physician assistant at any location needed by the patient. Whether the patient is in the clinic, bedridden at home, in a nearby hospital or nursing home or elsewhere, the clinic's physician and nurse practitioner and physician assistant should be able to care for the patient at that location and be reimbursed as a clinic for that service.

The committee's amendment waives the Title XIX requirement that a medicaid recipient be able to receive medicaid covered services from any qualified provider in the State to the extent that rural health clinic services are to be available only to those recipients who utilize rural health clinics.

Rural health clinics

H.R. 8422, as reported by the Ways and Means Committee, left the definition of "rural" to the Secretary. This committee is concerned that the term "rural" is susceptible to multiple definitions. HEW testified before the subcommittee on Health and the Environment in the July 29 hearing on the bill that it would define "rural" to include areas which are not urbanized and which have less than 50,000 population. The committee intends that the Secretary define "rural" in this manner.

H.R. 8422, as reported by the Ways and Means Committee authorizes reimbursement for clinics in rural areas which are "designated by the Secretary as having medically underserved populations under section 1302(7) of the Public Health Service Act." This committee is concerned that the criteria for determining "medically underserved populations" may exclude some areas which are also in need of additional personal health services. Because the proposed legislation is designed to address the problem of physician shortages, this committee amended the definition of rural health clinic to include facilities located in rural areas designated by the Secretary as areas with shortages of personal health services under section 1302(7) of the Public Health Service Act or as rural areas designated by the Secretary as "health manpower shortage area(s)" as described in section 332(a)(1)(A) of the Public Health Service Act. HEW advised the Committee that this definition would enable approximately 100 additional areas to be eligible for reimbursement.

H.R. 8422, as reported by the Ways and Means Committee, does not specifically address the consequences for a rural health clinic which is in operation in an area which loses its designation as a shortage area. This Committee amended the legislation so that such a clinic will continue to be reimbursed as a rural health clinic during a 5-year period beginning on the date such designation is lost. This committee is particularly concerned that the loss of area designation might jeopardize the financial viability of a rural health clinic. To insure that no clinic is closed due to the loss of area designation, the committee intends to review rural clinic reimbursement and, in particular, this issue within five years after enactment and before any clinic would be no longer eligible for certification by the Secretary.

This committee also amended the bill to include certain clinics which were in operation on July 1, 1977, and which would qualify as rural health clinics under all criteria set out by the bill except that the areas served by the clinics are not designated as shortage areas. This issue came to the committee's attention because of the rural health clinic development program being conducted by the North Carolina Office of Rural Health Services. At least two clinics developed by small communities, with the assistance of that office, are in sparsely populated, rural parts of counties in which large metropolitan areas are also located. While these communities are not designated as medically underserved populations or health manpower shortage areas, the communities and the Office of Rural Health Services found that additional health manpower was needed.

It is the intent of this committee to include private, not-for-profit rural health clinics which, on July 1, 1977, were in operation and employed nurse practitioners or physician assistants and which, on the date of enactment of this bill, comply with all criteria of the bill except that the areas served by the clinics are not designated as shortage areas. Clinics eligible for participation under this provision must have a patient population, as measured by the number of people actually served by (rather than the number of visits to) the clinic, of not more than 3,000. It also must be in an area within which there is no practicing physician (other than the physician who under a contractural arrangement with the clinic provides backup for the clinic's nurse practitioner or physician assistant) for a distance of 5 miles. Such a clinic will be eligible to participate as a rural health clinic for a period of 5 years beginning on the date of enactment of this bill. Eligibility is limited to 5 years to be consistent with potential limitations in other rural health clinics in areas which lose their designation. The committee intends to review the impact of this provision on these clinics at the same time it reviews the entire law.

Questions have been raised by interested parties as to whether other providers, such as private physicians and migrant health centers could qualify as rural health clinics. This committee intends that any provider who meets the requirements of this bill be eligible for reimbursement under the bill.

H.R. 8422, as reported by the Ways and Means Committee, authorizes the Secretary to promulgate requirements for rural clinics which are found to be "necessary [and] in the interest of the health and safety" of clinic patients. This committee recognizes that the facilities and operations of rural health clinics differ greatly from those of hospitals and other complex institutional facilities. It is this committee's intent that any additional requirements take into account the unique circumstances of rural health clinics and that the requirements be more flexible and less complex than those used for hospitals and large institutional facilities.

Nurse practitioners and physician assistants

H.R. 8422, as reported by the Ways and Means Committee, uses the term "primary care practitioner" to describe nurse practitioners and physician assistants. This committee believes that confusion could result from using the term "primary care practitioner" because it could be construed to include physicians. This committee prefers and, thus, amended the bill to use the terms "nurse practitioner" and "physician assistant". This committee supports the use of nurse practitioners and physician assistants as providers of primary health care services. It also supports other types of nurse practitioners, such as nurse mid-wives, who specialize in a particular range of services. This committee's intent is to include in the terms "nurse practitioner" and "physician assistant" any practitioners who have sufficient training, education, and experience, as determined by the Secretary, to provide quality health services in a rural health clinic.

Reimbursement for rural health clinic services

H.R. 8422, as reported by the Ways and Means Committee, authorizes medicare reimbursement at 80 percent of the costs which are reasonable and related to the costs of furnishing services or which are determined on other tests of reasonableness prescribed by the Secretary. Part I of this report explains what would be included in those costs. This committee's amendment to title XIX is intended to make medicaid reimbursement consistent with medicare reimbursement when both programs cover the same services. The amendment requires that in a rural health clinic which provides only rural health clinic services, so that medicare and medicaid are covering the same services, the determination of costs for medicaid reimbursement purposes will be made using the same tests of reasonableness which are established by this bill and are used by the Secretary in medicare reimbursement. The medicaid reimbursement rate would be 100 percent, rather than the 80 percent used by medicare because of the medicare coinsurance requirement. For those other ambulatory services covered only by medicaid, the determination of costs for medicaid reimbursement purposes would be based on tests of reasonableness prescribed by the Secretary. The medicaid reimbursement rate would be 100 percent, less any amount paid as a nominal copayment required under the State plan. (This provision is not intended to affect existing medicaid law which allows optional copayments.) The Secretary would use for medicaid the same guidelines established for medicare for identifying situations where costs would not be allowed without further investigation. (See pt. I of this report for an explanation of these guidelines.)

This committee recognizes that rural health clinics have a wide variety of administrative capabilities. By making medicare and medicaid reimbursement consistent when the same services are covered, the committee intends for all reporting of costs of a clinic which provides only rural health clinic services to be the same for both programs. By mandating a cost-based payment with one payment rate for a rural health clinic which provides rural health clinic services and other medicaid-covered ambulatory services, the committee intends for all medicaid financial reporting for all covered services to be accomplished through one report. The committee is aware that in some states which now cover rural health clinic services clinics are required to bill different medicaid fiscal agents for each of the several medicaid-covered services. The committee recognizes that such a reimbursement system is costly and administratively complex for the clinic and often absorbs limited clinic resources for administration instead of patient care. The committee expects the Secretary to evaluate all possible alternatives and to devise a system whereby the state can gain sufficient data for purposes of its match and the clinic can submit a single report of its cost experience.

The committee also intends for all reports and all other documents required to be submitted to be designed so that clinics with small or part-time administrative staffs which use relatively unsophisticated accounting methods can understand and complete them.

The committee is particularly concerned that abuse, such as that which occurs in the so-called medicaid mills in urban areas, does not occur in this program. The committee expects the Secretary to carefully review the administrative mechanisms utilized by medicare and medicaid fiscal agents to ascertain that they can detect such abuses. It is the committee's belief that if those agents carefully review clinic budgets and reports used in determining reimbursement rates, such abuses will not occur.

Certification of rural health clinics

H.R. 8422, as reported by the Ways and Means Committee, authorizes the Secretary to make agreements with appropriate State and local agencies to certify rural health clinics. The committee recognizes that the facilities and operations of rural health clinics differ greatly from those of hospitals and other complex institutional facilities; thus, clinic certification must take into account their unique circumstances and must be more flexible and less complex than those used for hospitals and large institutional facilities. It is the committee's intent that the Secretary determine that the State or local certification agency with which the agreement is made has an appropriation plan and personnel qualified to inspect such ambulatory care facilities.

The committee's amendment regarding medicaid would allow medicare certification to serve as certification for medicaid for the purposes of providing rural health clinic services. For those other medicaid ambulatory services not covered by medicare the committee's amendment requires rural health clinics to meet State certification standards for providers of those services. For example, a rural health clinic would have to comply with all State standards for family planning providers before it could be reimbursed for family planning services.

Demonstration projects for urban health clinics in medically underserved areas

H.R. 8422, as reported by the Ways and Means Committee, authorizes the Secretary to carry out demonstration projects in which physician-directed urban health clinics in medically underserved areas which employ nurse practitioners and physician assistants would be reimbursed by medicare on a cost-related basis. This committee supports this demonstration project but believes that it should parallel rural health clinic reimbursement. The committee was concerned that the term "physician-directed" would preclude the Secretary from including in the demonstration urban health clinics with part-time physicians, so the bill was amended to require the Secretary to include such clinics. The committee believes that section 222 of the Social Security Amendments of 1972 grants sufficient authority to HEW to include medicaid reimbursement in this demonstration. It is the committee's intent that medicaid be so included but that implementation of medicare reimbursement under the demonstration not be delayed while coordinating with States or medicaid. The committee intends that medicare and medicaid reimbursement under the demonstration be based on the same tests of reasonableness as used in medicare and medicaid reimbursement of rural health clinics. The committee does not believe that the urban character of an area should be used as a basis for differentials in determining appropriate reimbursement.

The committee recognizes that the variety of providers in urban areas which utilize nurse practitioners and physician assistants includes private physicians, small clinics with part-time physicians, public health clinics, and large federally funded clinics with several physicians and other health providers. It is the committee's intent that the demonstration projects include these types of providers so that the Secretary can evaluate the impact on each of these cost-related reimbursements.

Demonstration projects for comprehensive outpatient mental health centers

H.R. 8422, as reported by the Ways and Means Committee, directs the Secretary to develop and carry out demonstration projects to provide reimbursement under medicare for services provided in organized centers offering comprehensive outpatient mental health services. This committee supports this demonstration and intends that the Secretary carefully evaluate the capability of these centers to deliver quality services before including them in the demonstration. The committee expects the Secretary to carefully review qualifications of the personnel used by the center to insure that they are competent to deliver high quality care.

Demonstration projects for preventive health services in rural and urban health clinics

The committee recognizes that our present reimbursement system provides payment for the treatment of disease. The committee believes that mechanisms for paying for preventive health care services must be tested to determine whether the provision of such services will result in improved health status and will reduce health care costs. The committee believes that section 222 of the Social Security Amendments of 1972 provides broad authority for HEW to carry out demonstration projects to reimburse preventive health services. Because this authority exists the committee did not amend the bill, but it is the committee's intent that the Secretary will conduct demonstration projects in which rural health clinics covered by the bill and urban health clinics participating in the demonstration projects will be reimbursed on a cost basis for providing preventive health care. The committee intends for HEW to include a broad range of preventive health services and activities and expects that those services and activities will include:

(a) Physical exams and diagnostic services made in connection with such an exam for the purpose of assessing an individual's physical condition without regard to whether such individual has manifested symptoms of illness;

(b) Health education and counseling designed to prevent nutritional or other health problems of the individual, including counseling for conditions of terminal illness;

(c) Immunizations and services related thereto;

(d) Services for illness management designed to minimize handicapping and discomforting conditions due to a chronic illness;

(e) Preventive dental care; and

(f) Other activities carried out by clinic staff which promote health and well-being regardless of whether those activities are performed in the clinic, in local schools or in other public places in the community. The committee expects the demonstration project to be carried out on a broad enough scale to allow the Secretary to evaluate: (1) The effect on health status of providing such services; (2) the impact of providing such services on the rate of hospitalization, workdays lost and school absence; (3) the frequency and intensity of utilization of such services; (4) the appropriate staffing requirements of rural and urban health clinics for proper provision of such services; (5) the methods available for ensuring proper utilization and quality control of such services; (6) the extent to which services are considered and should be considered as preventive services; (7) the desirability of providing such services to individuals not eligible for medicare and medicaid; (8) the cost, including the cost per patient per year, projected cost, and cost effectiveness of providing preventive services to people who utilize rural and urban health clinics; (9) the appropriateness of cost base reimbursement and payment for such services; (10) the extent of payments made through private insurers for provision of such services; (11) present Federal and State funding for provision of such services; and (12) the appropriateness of including preventive services under title XVIII and XIX of the Social Security Act. The committee expects the Secretary to report to Congress no later than January 1, 1981, including any recommendations for legislative change which the Secretary finds necessary and desirable as a result of carrying out this demonstrtion project.

Transfer of Public Health Service hospital

The committee's amendment would authorize the transfer of the Galveston, Tex., Public Health Service Hospital to the Space Center Memorial Hospital in Nassau Bay, Tex. Such a transfer must be approved by the Congress pursuant to Public Law 93-155 which prohibits the closure of PHS hospitals without congressional consent.

SECTION-BY-SECTION ANALYSIS OF THE BILL

Part I of this report provides an analysis of sections 1, 3 and 4 (as numbered in the bill as ordered reported by this committee). That analysis is complete with the following additions.

Section 1. Medicare coverage for rural health clinics

In section 1(c): "rural health clinic" also includes a facility which is located in a "health manpower shortage area described in section 332(a)(1)(A) of [the Public Health Service] Act."

In section 1(c): a rural health clinic in an area which loses its designation as having a medically underserved population or as being a health manpower shortage area shall be allowed to continue to participate as a rural health clinic for the 5-year period beginning on the date such designation was lost.

In section 1(c): the term "primary care practitioner" is changed to "physician assistant" and "nurse practitioner", but the definition of that term is not substantially changed.

Section 2. Medicaid coverage for rural health clinics

Section 2(a) amends section 1905(a) of the Social Security Act to include the services of rural health clinics within the scope of benefits required to be covered by the State medicaid plan. Those services include rural health clinic services (as defined in section 1) and which are otherwise included in the plan.

Section 2(b) amends section 1905 of the Social Security Act to add a new subsection which defines the terms "rural health clinic services" and "rural health clinics."

Section 2(c) amends section 1902(a) of the Social Security Act to provide for payment for the services of a rural health clinic of 100 percent of costs which are reasonable and related to the costs of furnishing such services or based on such others tests of reasonableness as the Secretary may prescribe and in the case of service which are not covered by medicare, for 100 percent of costs based upon such tests of reasonableness as the Secretary may prescribe. Section 2(c) also waives the statewideness requirement under medicaid for rural health clinic services.

Section 2(d) amends section 1910 of the Social Security Act to provide for certification and approval of rural health clinics. Certification of a rural health clinic under title XVIII will serve as certification for rural health clinic services provided by a rural health clinic under title XIX. If the clinic provides other ambulatory services covered by medicaid only, the clinic must meet state certification requirements for providers of those services.

Section 2(e) is a conforming amendment.

Section 2(f) provides that amendments made by this section shall apply to services rendered on or after the first day of the first calendar quarter that begins more than six months after the date of enactment.

Section 3. Demonstration Projects for Clinics Employing Nurse Practitioners and Physician Assistants in Urban Areas (Section 2 in Part I)

Section 3(a) authorizes this demonstration at all clinics in urban medically underserved areas which employ nurse practitioners and physician assistants. (The requirement of "physician-directed" is deleted.)

Other Sections

Section 5 includes certain other clinics which comply with all standards set by the bill except that the areas in which those clinics are located are not medically underserved or health manpower short-

[illegible]

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[illegible]

[illegible]

[illegible]

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RURAL HEALTH CLINIC SERVICES

NOVEMBER 1, 1977.—Ordered to be printed

Mr. ULLMAN, from the committee of conference,
submitted the following

CONFERENCE REPORT

[To accompany H.R. 8422]

The committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 8422) to amend titles XVIII and XIX of the Social Security Act to provide payment for rural health clinic services, and for other purposes, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the Senate amendment insert the following:

MEDICARE AMENDMENTS

SECTION 1. (a) Section 1832(a) of the Social Security Act is amended—

(1) by striking out "paragraph (2)(B)" in paragraph (1) and inserting in lieu thereof "subparagraphs (B) and (D) of paragraph (2)"; and

(2) by striking out the period at the end of paragraph (2)(C) and inserting in lieu thereof "; and" and by adding the following new subparagraph at the end of paragraph (2):

"(D) rural health clinic services."

(b) Section 1833(a) of such Act is amended—

(1) by striking out "and" at the end of paragraph (1);

(2) by inserting "(except those services described in subparagraph (D) of section 1832(a)(2))" in paragraph (2) after "1832(a)(2)";

(3) by striking out the period at the end of paragraph (2) and inserting in lieu thereof ", and"; and

(4) by inserting the following new paragraph after paragraph (2):

"(3) in the case of services described in section 1832(a)(2)(D), 80 percent of costs which are reasonable and related to the cost of furnishing such services or on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under section 1861 (v)(1)(A)."

(c) The Secretary of Health, Education, and Welfare (hereinafter in this Act referred to as the "Secretary") shall conduct a study of the feasibility and desirability of imposing a copayment for each visit to a rural health clinic for rural health clinic services under part B of title XVIII of the Social Security Act, instead of the deductible and coinsurance amounts otherwise required under section 1833 of such Act with respect to the provision of such services. The Secretary shall report to the appropriate committees of Congress, not later than one year after the date of enactment of this Act, on such study and on any recommendations he may have for changes in the provisions of part B of title XVIII of the Social Security Act to reflect the findings of such study.

(d) Section 1861 of such Act is amended by adding at the end thereof the following new subsection:

"Rural Health Clinic Services

"(aa)(1) The term 'rural health clinic services' means—

"(A) physicians' services and such services and supplies as are covered under section 1861(s)(2)(A) if furnished as an incident to a physician's professional service,

"(B) such services furnished by a physician assistant or by a nurse practitioner and such services and supplies furnished as an incident to his service as would otherwise be covered if furnished by a physician or as an incident to a physician's service, and

"(C) in the case of a rural health clinic located in an area in which there exists a shortage of home health agencies, part-time or intermittent nursing care and related medical supplies (other than drugs and biologicals) furnished by a registered professional nurse or licensed practical nurse to a homebound individual under a written plan of treatment (i) established and periodically reviewed by a physician described in paragraph (2)(B), or (ii) established by a nurse practitioner or physician assistant and periodically reviewed and approved by a physician described in paragraph (2)(B),

when furnished to an individual as an outpatient of a rural health clinic.

"(2) The term 'rural health clinic' means a facility which—

"(A) is primarily engaged in providing rural health clinic services;

"(B) in the case of a facility which is not a physician-directed clinic, has an arrangement (consistent with the provisions of State and local law relative to the practice, performance, and delivery of health services) with one or more physicians (as defined in subsection (r)(1)) under which provision is made for the periodic review by such physicians of covered services furnished by physician assistants and nurse practitioners, the supervision and guidance by such physicians of physician assistants and nurse practitioners, the preparation by such physicians of such medical orders for care and treatment of clinic patients as may be necessary, and the availability of such physicians for such referral of and consultation for patients as is necessary and for advice and assistance in the management of medical emergencies; and in the case of a physician-directed clinic, such clinic has one or more of its staff physicians perform the activities accomplished through such an arrangement;

"(C) maintains clinical records on all patients;

"(D) has arrangements with one or more hospitals having agreements in effect under section 1866 for the referral and admission of

JOINT EXPLANATORY STATEMENT OF THE COMMITTEE ON CONFERENCE

The managers on the part of the House and the Senate at the conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 8422) to amend titles XVIII and XIX of the Social Security Act to provide payment for rural health clinic services, and for other purposes, submit the following joint statement to the House and the Senate in explanation of the effect of the action agreed upon by the managers and recommended in the accompanying conference report:

The Senate amendment struck out all of the House bill after the enacting clause and inserted a substitute text.

The House recedes from its disagreement to the amendment of the Senate with an amendment which is a substitute for the House bill and the Senate amendment. The differences between the House bill, the Senate amendment, and the substitute agreed to in conference are noted below, except for clerical corrections, conforming changes made necessary by agreements reached by the conferees, and minor drafting and clarifying changes.

1. *Substitution of part B deductible with copayment for rural health clinic services*

House bill.—The House bill contains no comparable provision.

Senate amendment.—The Senate amendment authorizes the Secretary to waive the part B deductible with respect to rural health clinic services and to require in lieu thereof copayments not to exceed $3 a visit and $60 a year, where he determines that such an alternative approach would be less costly.

Conference agreement.—The conference agreement requires the Secretary of Health, Education, and Welfare to study the feasibility and desirability of imposing a copayment for each visit to a rural health clinic instead of the medicare deductible and coinsurance. The Secretary is to report to the appropriate committees of Congress, not later than one year after the date of enactment, on such study and on any recommendations. The conferees note that the intent of the study is to evaluate approaches to the use of copayment that will not result in additional cost either to beneficiaries or rural clinics.

2. *Primary care practitioner*

House bill.—The House bill uses the term "primary care practitioner" to describe the nurse practitioners, physician assistants, medex and other practitioners whose services would be covered under the bill.

Senate amendment.—The Senate amendment deletes the term "primary care practitioner" and uses in lieu thereof the terms "nurse practitioner" and "physician assistant".

Conference agreement.—The conference agreement accepts the Senate amendment. It is the intent of the conferees that the services of a nurse midwife furnished through an otherwise eligible rural health clinic be covered as rural health clinic services.

3. *Coverage of home health services furnished by certain clinics*

House bill.—The House bill contains no comparable provision.

Senate amendment.—The Senate amendment provides that, where there exists a shortage of home health agencies, the rural health clinic services covered under medicare and medicaid could include any or all of the services presently covered by a home health agency regardless of whether a clinic could offer any of the skilled services (nursing care, speech therapy or physical therapy) presently required of home health agencies.

Conference agreement.—The conference agreement provides that, where there exists a shortage of home health agencies, the rural clinic services covered under medicare and medicaid could include part-time or intermittent nursing services and related supplies, to the extent permitted in regulations, furnished by a registered nurse or a licensed practical nurse to homebound patients, provided such services are furnished under a written plan of treatment (i) established and periodically reviewed by a physician, or (ii) established by a nurse practitioner or physician assistant and periodically reviewed and approved by a physician. It is the intent of the conferees that licensed vocational nurses shall be considered as licensed practical nurses for the purposes of this provision.

4. *Physician supervision arrangement*

House bill.—The House bill requires the rural health clinic to have an arrangement with one or more physicians under which the physician periodically reviews the services furnished by the nurse practitioner or physician assistant and prepares such medical orders for care and treatment of clinic patients as is necessary.

Senate amendment.—The Senate amendment modifies the House bill by providing that the medical orders are to be prepared jointly by the physician and the nurse practitioner or physician assistant.

Conference agreement.—The conference agreement accepts the House provision. The conferees note that medical orders are appropriately prepared by a physician. However, patient care plans, which involve nursing functions, are ordinarily prepared in consultation with the nurse practitioner and physician assistant.

5. *Clinic policies*

House bill.—The House bill requires a rural health clinic to have policies to govern the provision of covered services which are developed (and periodically reviewed) with the advice of a group of professional personnel, including one or more physicians and one or more nurse practitioners or physician assistants.

Senate amendment.—The Senate amendment substitutes for the House provision the requirement that the clinic have written policies to govern the management of the clinic and the services it furnishes.

Conference agreement.—The conference agreement accepts the House provision with a modification to clarify that the policies are to be written.

6. *Execution of policies*

House bill.—The House bill requires a rural health clinic to have a physician or primary care practitioner responsible for the execution of policies relating to the provision of the clinic's services.

Senate amendment.—The Senate amendment has no comparable provision.

Conference agreement.—The conference agreement accepts the House provision.

7. Clinical laboratory services

House bill.—The House bill requires each clinic to provide routine diagnostic services, including such clinical laboratory services as are prescribed by the Secretary. The House bill also provides that a clinic's laboratory shall be treated as a physician's office for the purpose of licensure and meeting any health and safety standards for clinical laboratories established by the Secretary.

Senate amendment.—The Senate amendment modifies the House bill to delete the requirement with respect to the provision of clinical laboratory services.

Conference agreement.—The conference agreement accepts the House provision.

8. Emergency drugs

House bill.—The House bill requires the clinic to have available for administration at least such drugs and biologicals as are determined by the Secretary to be necessary for the care and treatment of emergency cases.

Senate amendment.—The Senate amendment has no comparable provision.

Conference agreement.—The conference agreement provides that a clinic is to have such drugs and biologicals available as are determined by the Secretary to be necessary for treatment of emergency cases to the extent allowed by State and Federal law.

9. Utilization review

House bill.—The House bill contains no comparable provision.

Senate amendment.—The Senate amendment requires a rural health clinic to have appropriat procedures for utilization review.

Conference agreement.—The conference agreement requires clinics to have procedures for the review of utilization of services to the extent the Secretary determines necessary and feasible.

10. Eligible clinics

House bill.—The House bill defines a rural health clinic as one located in a rural area designated by the Secretary as having medically underserved populations under section 1302(7) of the Public Health Service Act.

Senate amendment.—The Senate amendment defines a rural health clinic as a facility located:

(1) in a rural area designated by the Secretary as having medically underserved populations under section 1302(7) of the Public Health Service Act,

(2) in an area (other than an urbanized area as defined by the Bureau of the Census) in which the supply of medical services is not sufficient to meet the needs of individuals therein, or

(3) in an urbanized area (so defined) if the majority of patients served by such facility reside in an area described in paragraph (1) or (2).

Conference agreement.—The conference agreement provides that clinics are eligible which are located in areas which are not urbanized and which have been designated by the Secretary as—

(1) having medically underserved populations (under title XIII of the Public Health Service Act), or

(2) primary medical care manpower shortage areas (under title III of the Public Health Service Act).

The agreement also provides for the eligibility of any private, nonprofit health care clinic which meets the requirements for a rural health clinic, except that it is not located in either of the shortage areas described above, and on July 1, 1977—

(A) was located in a nonurbanized area, and

(B) was located in an area where the supply of physicians was insufficient (as determined by the Secretary).

11. Grandfathering of clinics

House bill.—The House bill provides that a clinic which qualifies as a rural health clinic and is located in an area which subsequently loses its designation as a rural or medically underserved area would continue to be eligible for medicare and medicaid reimbursement as a rural health clinic.

Senate amendment.—The Senate amendment has no comparable provision.

Conference agreement.—The conference agreement accepts the House provision.

12. Review of capital expenditures

House bill.—The House bill contains no comparable provision.

Senate amendment.—The Senate amendment provides that rural health clinics would be subject to review of capital expenditures under programs established pursuant to section 1122 of the Social Security Act.

Conference agreement.—The conference agreement accepts the House position with the understanding that review of capital expenditures in ambulatory settings will be considered at a later date.

13. Comprehensive outpatient mental health centers

House bill.—The House bill requires the Secretary to carry out a demonstration project to provide reimbursement for services furnished in organized centers offering comprehensive mental health services.

Senate amendment.—The Senate amendment requires the Secretary to submit a report, not later than April, 1978, on the advantages and disadvantages of extending medicare coverage to mental health centers.

Conference agreement.—The conference agreement accepts the Senate provision with the modifications that the report is to be submitted within 6 months after enactment and the study is to include, with separate evaluations, centers for treatment of alcoholism and drug abuse. The conferees expect the Secretary to conduct demonstration projects, under the authority of section 222 of Public Law 92–603, to provide coverage for preventive services furnished by rural health clinic services.

14. Arrangements for clinics under medicaid

House bill.—The House bill clarifies that the requirement that clinics must agree not to charge medicare patients for covered items or services except for the amount of the medicare part B deductible or coinsurance is not applicable for the purposes of reimbursement under medicaid. The House bill also clarifies that services offered by a clinic which are covered only under the medicaid program are to be subject to title XIX requirements for physician arrangements for supervision and related activities.

Senate amendment.—The Senate amendment contains no comparable provision.

Conference agreement.—The conference agreement accepts the House provision.

15. Medicaid effective date

House bill.—The House bill provides that the State medicaid plan of all States which authorize the medical practice of nurse practitioners or physician assistants is to provide reimbursement for rural health clinic services beginning the first calendar quarter beginning more than six months after the date of enactment.

Senate amendment.—The Senate amendment further provides that, if legislation is required to conform the State plan, the requirement is to be effective the first calendar quarter beginning after the close of the State legislative session.

Conference agreement.—The conference agreement accepts the Senate amendment.

16. Disclosure of mailing addresses to National Institute for Occupational Safety and Health

House bill.—The House bill contains no comparable provision.

Senate amendment.—The Senate amendment would authorize the Secretary of the Treasury, upon written request, to disclose mailing addresses to officers and employees of the National Institute for Occupational Safety and Health (NIOSH) solely for the purposes of locating and determining the vital status of persons who, in their occupations, are, or may have been, exposed to a hazardous substance and referring sick or injured workers for medical care and treatment.

Conference agreement.—The conference agreement includes the substance of the Senate amendment with a technical amendment which clarifies the language of the Senate amendment and which restructures the pertinent section (6103(m)) of the Internal Revenue Code. The conference agreement is not intended to allow the disclosure of the mailing addresses of any taxpayer for any other studies that have been or will be undertaken by NIOSH, except for the specific purpose stated in the conference report.

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WILLIAM D. HATHAWAY,
BOB DOLE,
BOB PACKWOOD,
Managers on the Part of the Senate.

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Finder's Aid

P.L. 95-216 (91 Stat. 1509) Approved December 20, 1977
Social Security Amendments of 1977

Subject	SS Act Section	P.L. Sec.	91 Stat.	H.Rep. 95-702-I	H.Rep. 95-702-II	S.Rep. 95-572	H.C.Rep. 95-837*
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*Senate Conference Report 95-612 is identical.

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Subject	SS Act Section	P.L. Sec.	91 Stat.	H.Rep. 95-702-I	H.Rep. 95-702-II	S.Rep. 95-572	H.C.Rep. 95-837
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Widower's Benefits--Effective Date--Offset--Delayed Retirement	202(f)(3)(A)	336(b)(1)	1547	--	--	4, 27 35	2, 68 73
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Subject	SS Act Section	P.L. Sec.	91 Stat.	H.Rep. 95-702-I	H.Rep. 95-702-II	S.Rep. 95-572	H.C.Rep. 95-837
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Subject	SS Act Section	P.L. Sec.	91 Stat.	H.Rep. 95-702-I	H.Rep. 95-702-II	S.Rep. 95-572	H.C.Rep 95-837
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Subject	SS Act Section	P.L. Sec.	91 Stat.	H.Rep. 95-702-I	H.Rep. 95-702-II	S.Rep. 95-572	H.C.Rep. 95-837
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Public Law 95-216
95th Congress

An Act

To amend the Social Security Act and the Internal Revenue Code of 1954 to strengthen the financing of the social security system, and for other purposes.

Dec. 20, 1977
[H.R. 9346]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act, with the following table of contents, may be cited as the "Social Security Amendments of 1977".

Social Security Amendments of 1977.
42 USC 1305 note.

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TITLE I—PROVISIONS RELATING TO THE FINANCING OF THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE PROGRAM

ADJUSTMENTS IN TAX RATES

26 USC 3101.

SEC. 101. (a)(1) Section 3101(a) of the Internal Revenue Code of 1954 (relating to rate of tax on employees for purposes of old-age, survivors, and disability insurance) is amended by striking out paragraphs (1) and (2) and inserting in lieu thereof the following:

"(1) with respect to wages received during the calendar years 1974 through 1977, the rate shall be 4.95 percent;

"(2) with respect to wages received during the calendar year 1978, the rate shall be 5.05 percent;

"(3) with respect to wages received during the calendar years 1979 and 1980, the rate shall be 5.08 percent;

"(4) with respect to wages received during the calendar year 1981, the rate shall be 5.35 percent;

"(5) with respect to wages received during the calendar years 1982 through 1984, the rate shall be 5.40 percent;

"(6) with respect to wages received during the calendar years 1985 through 1989, the rate shall be 5.70 percent; and

"(7) with respect to wages received after December 31, 1989, the rate shall be 6.20 percent.".

(2) Section 3111(a) of such Code (relating to rate of tax on employers for purposes of old-age, survivors, and disability insurance) is amended by striking out paragraphs (1) and (2) and inserting in lieu thereof the following:

Post, p. 1537.
26 USC 3111.

"(1) with respect to wages paid during the calendar years 1974 through 1977, the rate shall be 4.95 percent;

"(2) with respect to wages paid during the calendar year 1978, the rate shall be 5.05 percent;

"(3) with respect to wages paid during the calendar years 1979 and 1980, the rate shall be 5.08 percent;

"(4) with respect to wages paid during the calendar year 1981, the rate shall be 5.35 percent;

"(5) with respect to wages paid during the calendar years 1982 through 1984, the rate shall be 5.40 percent;

"(6) with respect to wages paid during the calendar years 1985 through 1989, the rate shall be 5.70 percent; and

"(7) with respect to wages paid after December 31, 1989, the rate shall be 6.20 percent.".

(3) Section 1401(a) of such Code (relating to rate of tax on self-employment income for purposes of old-age, survivors, and disability insurance) is amended by striking out "a tax" and all that follows and inserting in lieu thereof the following: "a tax as follows:

26 USC 1401.

"(1) in the case of any taxable year beginning before January 1, 1978, the tax shall be equal to 7.0 percent of the amount of the self-employment income for such taxable year;

"(2) in the case of any taxable year beginning after December 31, 1977, and before January 1, 1979, the tax shall be equal to 7.10 percent of the amount of the self-employment income for such taxable year;

"(3) in the case of any taxable year beginning after December 31, 1978, and before January 1, 1981, the tax shall be equal to 7.05 percent of the amount of the self-employment income for such taxable year;

"(4) in the case of any taxable year beginning after December 31, 1980, and before January 1, 1982, the tax shall be equal to 8.00 percent of the amount of the self-employment income for such taxable year;

"(5) in the case of any taxable year beginning after December 31, 1981, and before January 1, 1985, the tax shall be equal to 8.05 percent of the amount of the self-employment income for such taxable year;

"(6) in the case of any taxable year beginning after December 31, 1984, and before January 1, 1990, the tax shall be equal to 8.55 percent of the amount of the self-employment income for such taxable year; and

"(7) in the case of any taxable year beginning after December 31, 1989, the tax shall be equal to 9.30 percent of the amount of the self-employment income for such taxable year.".

(b)(1) Section 3101(b) of such Code (relating to rate of tax on employees for purposes of hospital insurance) is amended by striking

Hospital insurance.
26 USC 3101.

out paragraphs (1) through (4) and inserting in lieu thereof the following:

"(1) with respect to wages received during the calendar years 1974 through 1977, the rate shall be 0.90 percent;

"(2) with respect to wages received during the calendar year 1978, the rate shall be 1.00 percent;

"(3) with respect to wages received during the calendar years 1979 and 1980, the rate shall be 1.05 percent;

"(4) with respect to wages received during the calendar years 1981 through 1984, the rate shall be 1.30 percent;

"(5) with respect to wages received during the calendar year 1985, the rate shall be 1.35 percent; and

"(6) with respect to wages received after December 31, 1985, the rate shall be 1.45 percent.".

26 USC 3111. (2) Section 3111(b) of such Code (relating to rate of tax on employers for purposes of hospital insurance) is amended by striking out paragraphs (1) through (4) and inserting in lieu thereof the following:

"(1) with respect to wages paid during the calendar years 1974 through 1977, the rate shall be 0.90 percent;

"(2) with respect to wages paid during the calendar year 1978, the rate shall be 1.00 percent;

"(3) with respect to wages paid during the calendar years 1979 and 1980, the rate shall be 1.05 percent;

"(4) with respect to wages paid during the calendar years 1981 through 1984, the rate shall be 1.30 percent;

"(5) with respect to wages paid during the calendar year 1985, the rate shall be 1.35 percent; and

"(6) with respect to wages paid after December 31, 1985, the rate shall be 1.45 percent.".

26 USC 1401. (3) Section 1401(b) of such Code (relating to tax on self-employment income for purposes of hospital insurance) is amended by striking out paragraphs (1) through (4) and inserting in lieu thereof the following:

"(1) in the case of any taxable year beginning after December 31, 1973, and before January 1, 1978, the tax shall be equal to 0.90 percent of the amount of the self-employment income for such taxable year;

"(2) in the case of any taxable year beginning after December 31, 1977, and before January 1, 1979, the tax shall be equal to 1.00 percent of the amount of the self-employment income for such taxable year;

"(3) in the case of any taxable year beginning after December 31, 1978, and before January 1, 1981, the tax shall be equal to 1.05 percent of the amount of the self-employment income for such taxable year;

"(4) in the case of any taxable year beginning after December 31, 1980, and before January 1, 1985, the tax shall be equal to 1.30 percent of the amount of the self-employment income for such taxable year;

"(5) in the case of any taxable year beginning after December 31, 1984, and before January 1, 1986, the tax shall be equal to 1.35 percent of the amount of the self-employment income for such taxable year; and

"(6) in the case of any taxable year beginning after December 31, 1985, the tax shall be equal to 1.45 percent of the amount of the self-employment income for such taxable year.".

ALLOCATIONS TO DISABILITY INSURANCE TRUST FUND

42 USC 401.

SEC. 102. (a)(1) Section 201(b)(1) of the Social Security Act is amended by striking out clauses (G) through (J) and inserting in lieu thereof the following: "(G) 1.55 per centum of the wages (as so defined) paid after December 31, 1977, and before January 1, 1979, and so reported, (H) 1.50 per centum of the wages (as so defined) paid after December 31, 1978, and before January 1, 1981, and so reported, (I) 1.65 per centum of the wages (as so defined) paid after December 31, 1980, and before January 1, 1985, and so reported, (J) 1.90 per centum of the wages (as so defined) paid after December 31, 1984, and before January 1, 1990, and so reported, and (K) 2.20 per centum of the wages (as so defined) paid after December 31, 1989, and so reported.".

(2) Section 201(b)(2) of such Act is amended by striking out clauses (G) through (J) and inserting in lieu thereof the following: "(G) 1.090 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1977, and before January 1, 1979, (H) 1.0400 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1978, and before January 1, 1981, (I) 1.2375 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1980, and before January 1, 1985, (J) 1.4250 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1984, and before January 1, 1990, and (K) 1.650 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1989,".

INCREASES IN EARNINGS BASE

42 USC 430.

SEC. 103. (a)(1) Section 230(a) of the Social Security Act is amended by inserting "or (c)" after "determined under subsection (b)".

(2) Section 230(b) of such Act is amended by striking out "shall be" in the matter preceding paragraph (1) and inserting in lieu thereof "shall (subject to subsection (c)) be".

Infra.

Contribution and benefit base.

(b) Section 230(c) of such Act is amended—

(1) by inserting "(1)" immediately before "the 'contribution and benefit base' "; and

(2) by striking out "section." and inserting in lieu thereof the following:

"section, and (2) the 'contribution and benefit base' with respect to remuneration paid (and taxable years beginning)—

"(A) in 1978 shall be $17,700,
"(B) in 1979 shall be $22,900,
"(C) in 1980 shall be $25,900, and
"(D) in 1981 shall be $29,700.

For purposes of determining under subsection (b) the 'contribution and benefit base' with respect to remuneration paid (and taxable years beginning) in 1982 and subsequent years, the dollar amounts specified in clause (2) of the preceding sentence shall be considered to have resulted from the application of such subsection (b) and to be the amount determined (with respect to the years involved) under that subsection. For purposes of determining employer tax liability under section 3221(a) of the Internal Revenue Code of 1954, for purposes of

26 USC 3221.

26 USC 3211.
45 USC 231b.

determining the portion of the employee representative tax liability under section 3211(a) of such Code which results from the application of the 9.5 percent rate specified therein, and for purposes of computing average monthly compensation under section 3(j) of the Railroad Retirement Act of 1974, except with respect to annuity amounts determined under section 3(a) or (3)(f)(3) of such Act, clause (2) and the preceding sentence of this subsection shall be disregarded.".

42 USC 430.

(c)(1) Section 230 of such Act is further amended by adding at the end thereof the following new subsection:

29 USC 1322.

"(d) Notwithstanding any other provision of law, the contribution and benefit base determined under this section for any calendar year after 1976 for purposes of section 4022(b)(3)(B) of Public Law 93-406, with respect to any plan, shall be the contribution and benefit base that would have been determined for such year if this section as in effect immediately prior to the enactment of the Social Security Amendments of 1977 had remained in effect without change.".

Effective date.
42 USC 430 note.

(2) The amendment made by paragraph (1) shall apply with respect to plan terminations occurring after the date of the enactment of this Act.

42 USC 415.

(d)(1) The second sentence of section 215(i)(2)(D)(v) of such Act is amended by striking out "is equal to one-twelfth of the new contribution and benefit base" and inserting in lieu thereof "is equal to, or exceeds by less than $5, one-twelfth of the new contribution and benefit base".

(2) The third sentence of section 215(i)(2)(D)(v) of such Act is amended by striking out all that follows "clause (iv)" and inserting in lieu thereof "plus 20 percent of the excess of the second figure in the last line of column III as extended under the preceding sentence over such second figure for the calendar year in which the table of benefits is revised.".

EFFECTIVE DATE

26 USC 1401 note.

SEC. 104. The amendments made by this title shall apply with respect to remuneration paid or received, and taxable years beginning, after 1977.

TITLE II—STABILIZATION OF REPLACEMENT RATES IN THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE PROGRAM

COMPUTATION OF PRIMARY INSURANCE AMOUNT

42 USC 415.

SEC. 201. (a) Section 215(a) of the Social Security Act is amended to read as follows:

"(a)(1)(A) The primary insurance amount of an individual shall (except as otherwise provided in this section) be equal to the sum of—

"(i) 90 percent of the individual's average indexed monthly earnings (determined under subsection (b)) to the extent that such earnings do not exceed the amount established for purposes of this clause by subparagraph (B),

"(ii) 32 percent of the individual's average indexed monthly earnings to the extent that such earnings exceed the amount established for purposes of clause (i) but do not exceed the amount established for purposes of this clause by subparagraph (B), and "(iii) 15 percent of the individual's average indexed monthly earnings to the extent that such earnings exceed the amount established for purposes of clause (ii),

rounded in accordance with subsection (g), and thereafter increased as provided in subsection (i).

"(B)(i) For individuals who initially become eligible for old-age or disability insurance benefits, or who die (before becoming eligible of such benefits), in the calendar year 1979, the amount established for purposes of clause (i) and (ii) of subparagraph (A) shall be $180 and $1,085, respectively.

"(ii) For individuals who initially become eligible for old-age or disability insurance benefits, or who die (before becoming eligible for such benefits), in any calendar year after 1979, each of the amounts so established shall equal the product of the corresponding amount established with respect to the calendar year 1979 under clause (i) of this subparagraph and the quotient obtained by dividing—

"(I) the average of the total wages (as defined in regulations of the Secretary and computed without regard to the limitations specified in section 209(a)) reported to the Secretary of the Treasury or his delegate for the second calendar year preceding the calendar year for which the determination is made, by

42 USC 409.

"(II) the average of the total wages (as so defined and computed) reported to the Secretary of the Treasury or his delegate for the calendar year 1977.

"(iii) Each amount established under clause (ii) for any calendar year shall be rounded to the nearest $1, except that any amounts so established which is a multiple of $0.50 but not of $1 shall be rounded to the next higher $1.

"(C)(i) No primary insurance amount computed under subparagraph (A) may be less than—

"(I) the dollar amount set forth on the first line of column IV in the table of benefits contained in (or deemed to be contained in) this subsection as in effect in December 1978, rounded (if not a multiple of $1) to the next higher multiple of $1, or

"(II) an amount equal to $11.50 multiplied by the individual's years of coverage in excess of 10, or the increased amount determined for purposes of this subdivision under subsection (i),

whichever is greater. No increase under subsection (i), except as provided in subsection (i)(2)(A), shall apply to the dollar amount specified in subdivision (I) of this clause.

"Years of coverage."

"(ii) For purposes of clause (i)(II), the term 'years of coverage' with respect to any individual means the number (not exceeding 30) equal to the sum of (I) the number (not exceeding 14 and disregarding any fraction) determined by dividing (a) the total of the wages credited to such individual (including wages deemed to be paid prior to 1951 to such individual under section 217, compensation under the Railroad Retirement Act of 1937 prior to 1951 which is creditable to such individual pursuant to this title, and wages deemed to be paid prior to 1951 to such individual under section 231) for years after 1936 and before 1951 by (b) $900, plus (II) the number equal to the number of years after 1950 each of which is a computation base year (within the meaning of subsection (b)(2)(B)(ii)) and in each of which he is credited with wages (including wages deemed to be paid to such individual under section 217, compensation under the Railroad Retirement Act of 1937 or 1974 which is creditable to such individual pursuant to this title, and wages deemed to be paid to such individual under section 229) and self-employment income of not less than 25

Post, p. 1529.
45 USC 228a.
42 USC 431.
45 USC 228a, 231.
Post, p. 1554.

percent of the maximum amount which, pursuant to subsection (e), may be counted for such year, or of not less than 25 percent of the maximum amount which could be so counted for such year (in the case of a year after 1977) if section 230 as in effect immediately prior to the enactment of the Social Security Amendments of 1977 had remained in effect without change.

Ante, p. 1513; *Post*, p. 1554.

Publication in Federal Register.

"(D) In each calendar year after 1978 the Secretary shall publish in the Federal Register, on or before November 1, the formula for computing benefits under this paragraph and for adjusting wages and self-employment income under subsection (b)(3) in the case of an individual who becomes eligible for an old-age insurance benefit, or (if earlier) becomes eligible for a disability insurance benefit or dies, in the following year, and the average of the total wages (as described in subparagraph (B)(ii)(I)) on which that formula is based. With the initial publication required by this subparagraph, the Secretary shall also publish in the Federal Register the average of the total wages (as so described) for each calendar year after 1950.

Publication in Federal Register.

"(2)(A) A year shall not be counted as the year of an individual's death or eligibility for purposes of this subsection or subsection (i) in any case where such individual was entitled to a disability insurance benefit for any of the 12 months immediately preceding the month of such death or eligibility (but there shall be counted instead the year of the individual's eligibility for the disability insurance benefit or benefits to which he was entitled during such 12 months).

"(B) In the case of an individual who was entitled to a disability insurance benefit for any of the 12 months before the month in which he became entitled to an old-age insurance benefit, became reentitled to a disability insurance benefit, or died, the primary insurance amount for determining any benefit attributable to that entitlement, reentitlement, or death is the greater of—

"(i) the primary insurance amount upon which such disability insurance benefit was based, increased by the amount of each general benefit increase (as defined in subsection (i)(3)), and each increase provided under subsection (i)(2), that would have applied to such primary insurance amount had the individual remained entitled to such disability insurance benefit until the month in which he became so entitled or reentitled or died, or

"(ii) the amount computed under paragraph (1)(C).

"(C) In the case of an individual who was entitled to a disability insurance benefit for any month, and with respect to whom a primary insurance amount is required to be computed at any time after the close of the period of the individual's disability (whether because of such individual's subsequent entitlement to old-age insurance benefits or to a disability insurance benefit based upon a subsequent period of disability, or because of such individual's death), the primary insurance amount so computed may in no case be less than the primary insurance amount with respect to which such former disability insurance benefit was most recently determined.

"(3)(A) Paragraph (1) applies only to an individual who was not eligible for an old-age insurance benefit prior to January 1979 and who in that or any succeeding month—

"(i) becomes eligible for such a benefit,

"(ii) becomes eligible for a disability insurance benefit, or

"(iii) dies,

and (except for subparagraph (C)(i)(II) thereof) it applies to every such individual except to the extent otherwise provided by paragraph (4).

Eligibility.

"(B) For purposes of this title, an individual is deemed to be eligible—

"(i) for old-age insurance benefits, for months beginning with the month in which he attains age 62, or

"(ii) for disability insurance benefits, for months beginning with the month in which his period of disability began as provided under section 216(i)(2)(C),

42 USC 416.

except as provided in paragraph (2)(A) in cases where fewer than 12 months have elapsed since the termination of a prior period of disability.

Limitations.

"(4) Paragraph (1) (except for subparagraph (C)(i)(II) thereof) does not apply to the computation or recomputation of a primary insurance amount for—

"(A) an individual who was eligible for a disability insurance benefit for a month prior to January 1979 unless, prior to the month in which occurs the event described in clause (i), (ii), or (iii) of paragraph (3)(A), there occurs a period of at least 12 consecutive months for which he was not entitled to a disability insurance benefit, or

"(B) an individual who had wages or self-employment income credited for one or more years prior to 1979, and who was not eligible for an old-age or disability insurance benefit, and did not die, prior to January 1979, if in the year for which the computation or recommendation would be made the individual's primary insurance amount would be greater if computed or recomputed—

"(i) under section 215(a) as in effect in December 1978, for purposes of old-age insurance benefits in the case of an individual who becomes eligible for such benefits prior to 1984, or

"(ii) as provided by section 215(d), in the case of an individual to whom such section applies.

Post, pp. 1519, 1520.

In determining whether an individual's primary insurance amount would be greater if computed or recomputed as provided in subparagraph (B), (I) the table of benefits in effect in December 1978 shall be applied without regard to any increases in that table which may become effective (in accordance with subsection (i)(4)) for years after 1978 (subject to clause (iii) of subsection (i)(2)(A) but without regard to clauses (iv) and (v) thereof) and (II) such individual's average monthly wage shall be computed as provided by subsection (b)(4).

"(5) For purposes of computing the primary insurance amount (after December 1978) of an individual to whom paragraph (1) does not apply (other than an individual described in paragraph (4)(B)), this section as in effect in December 1978 shall remain in effect, except that, effective for January 1979, the dollar amount specified in paragraph (3) of subsection (a) shall be increased to $11.50. The table for determining primary insurance amounts and maximum family benefits contained in this section in December 1978 shall be revised as provided by subsection (i) for each year after 1978.".

(b) Section 215(b) of such Act is amended to read as follows:

42 USC 415.

"Average Indexed Monthly Earnings; Average Monthly Wage

"(b)(1) An individual's average indexed monthly earnings shall be equal to the quotient obtained by dividing—

"(A) the total (after adjustment under paragraph (3)) of his wages paid in and self-employment income credited to his benefit computation years (determined under paragraph (2)), by

"(B) the number of months in those years.

"(2)(A) The number of an individual's benefit computation years equals the number of elapsed years, reduced by five, except that the number of an individual's benefit computation years may not be less than two.

Definitions.

"(B) For purposes of this subsection with respect to any individual—

"(i) the term 'benefit computation years' means those computation base years, equal in number to the number determined under subparagraph (A), for which the total of such individual's wages and self-employment income, after adjustment under paragraph (3), is the largest;

"(ii) the term 'computation base years' means the calendar years after 1950 and before—

"(I) in the case of an individual entitled to old-age insurance benefits, the year in which occurred (whether by reason of section 202(j)(1) or otherwise) the first month of that entitlement; or

Post, p. 1542.

"(II) in the case of an individual who has died (without having become entitled to old-age insurance benefits), the year succeeding the year of his death;

except that such term excludes any calendar year entirely included in a period of disability; and

"(iii) the term 'number of elapsed years' means (except as otherwise provided by section 104(j)(2) of the Social Security Amendments of 1972) the number of calendar years after 1950 (or, if later, the year in which the individual attained age 21) and before the year in which the individual died, or, if it occurred earlier (but after 1960), the year in which he attained age 62; except that such term excludes any calendar year any part of which is included in a period of disability.

42 USC 414 note.

"(3)(A) Except as provided by subparagraph (B), the wages paid in and self-employment income credited to each of an individual's computation base years for purposes of the selection therefrom of benefit computation years under paragraph (2) shall be deemed to be equal to the product of—

"(i) the wages and self-employment income paid in or credited to such year (as determined without regard to this subparagraph), and

"(ii) the quotient obtained by dividing—

"(I) the average of the total wages (as defined in regulations of the Secretary and computed without regard to the limitations specified in section 209(a)) reported to the Secretary of the Treasury or his delegate for the second calendar year (after 1976) preceding the earliest of the year of the individual's death, eligibility for an old-age insurance benefit, or eligibility for a disability insurance benefit (except that the year in which the individual dies, or becomes eligible, shall not be considered as such year if the individual was entitled to disability insurance benefits for any month in the 12-month period immediately preceding such death or eligibility, but there shall be counted instead the year of the individual's eligibility for the disability insurance benefit to which he was entitled in such 12-month period), by

42 USC 409.

"(II) the average of the total wages (as so defined and computed) reported to the Secretary of the Treasury or his delegate for the computation base year for which the determination is made.

"(B) Wages paid in or self-employment income credited to an individual's computation base year which—

"(i) occurs after the second calendar year specified in subparagraph (A)(ii)(I), or

"(ii) is a year treated under subsection (f)(2)(C) as though it were the last year of the period specified in paragraph (2)(B)(ii),

shall be available for use in determining an individual's benefit computation years, but without applying subparagraph (A) of this paragraph.

"(4) For purposes of determining the average monthly wage of an individual whose primary insurance amount is computed (after 1978) under section 215(a) or 215(d) as in effect (except with respect to the table contained therein) in December 1978, by reason of subsection (a)(4)(B), this subsection as in effect in December 1978 shall remain in effect, except that paragraph (2)(C) (as then in effect) shall be deemed to provide that 'computation base years' include only calendar years in the period after 1950 (or 1936, if applicable) and prior to the year in which occurred the first month for which the individual was eligible (as defined in subsection (a)(3)(B) as in effect in January 1979) for an old-age or disability insurance benefit, or, if earlier, the year in which he died. Any calendar year all of which is included in a period of disability shall not be included as a computation base year for such purposes.".

Ante, p. 1514.
Post, p. 1520.

(c) Section 215(c) of such Act is amended to read as follows:

42 USC 415.

"Application of Prior Provisions in Certain Cases

"(c) This subsection as in effect in December 1978 shall remain in effect with respect to an individual to whom subsection (a)(1) does not apply by reason of the individual's eligibility for an old-age or disability insurance benefit, or the individual's death, prior to 1979.".

(d)(1) The matter in the text of section 215(d) of such Act which precedes paragraph (1)(C) is amended to read as follows:

Primary insurance benefit, computation.

"(d)(1) For purposes of column I of the table appearing in subsection (a), as that subsection was in effect in December 1977, an individual's primary insurance benefit shall be computed as follows:

"(A) The individual's average monthly wage shall be determined as provided in subsection (b), as in effect in December 1977 (but without regard to paragraph (4) thereof), except that for purposes of paragraphs (2)(C) and (3) of that subsection (as so in effect) 1936 shall be used instead of 1950.

"(B) For purposes of subparagraphs (B) and (C) of subsection (b)(2) (as so in effect)—

"(i) the total wages prior to 1951 (as defined in subparagraph (C) of this paragraph) of an individual who attained age 21 after 1936 and prior to 1950 shall be divided by the number of years (hereinafter in this subparagraph referred to as the 'divisor') elapsing after the year in which the individual attained age 20 and prior to 1951; and

"(ii) the total wages prior to 1951 (as defined in subparagraph (C) of this paragraph) of an individual who attained age 21 after 1949 shall be divided by the number of years (hereinafter in this subparagraph referred to as the 'divisor') elapsing after 1949 and prior to 1951.

The quotient so obtained shall be deemed to be the individual's wages credited to each of the years which were used in computing the amount of the divisor, except that—

"(iii) if the quotient exceeds $3,000, only $3,000 shall be deemed to be the individual's wages for each of the years which were used in computing the amount of the divisor, and the remainder of the individual's total wages prior to 1951 (I) if less than $3,000, shall be deemed credited to the year immediately preceding the earliest year used in computing the amount of the divisor, or (II) if $3,000 or more, shall be deemed credited, in $3,000 increments, to the year immediately preceding the earliest year used in computing the amount of the divisor and to each year consecutively preceding that year, with any remainder less than $3,000 being credited to the year immediately preceding the earliest year to which a full $3,000 increment was credited; and

"(iv) no more than $42,000 may be taken into account, for purposes of this subparagraph, as total wages after 1936 and prior to 1951.".

42 USC 415.

(2) Section 215(d)(1)(D) of such Act is amended to read as follows:

"(D) The individual's primary insurance benefit shall be 40 percent of the first $50 of his average monthly wage as computed under this subsection, plus 10 percent of the next $200 of his average monthly wage, increased by 1 percent for each increment year. The number of increment years is the number, not more than 14 nor less than 4, that is equal to the individual's total wages prior to 1951 divided by $1,650 (disregarding any fraction).".

(3) Section 215(d)(3) of such Act is amended (A) by striking out "in the case of an individual" and all that follows and inserting in lieu thereof the following "in the case of an individual who had a period of disability which began prior to 1951, but only if the primary insurance amount resulting therefrom is higher than the primary insurance amount resulting from the application of this section (as amended by the Social Security Amendments of 1967) and section 220.".

42 USC 420.

(4) Section 215(d) of such Act is further amended by adding at the end thereof the following new paragraph:

"(4) The provisions of this subsection as in effect in December 1977 shall be applicable to individuals who become eligible for old-age or disability insurance benefits or die prior to 1978.".

(e) Section 215(e) of such Act is amended—

(1) by striking out "average monthly wage" each place it appears and inserting in lieu thereof "average indexed monthly earnings or, in the case of an individual whose primary insurance amount is computed under section 215(a) as in effect prior to January 1979, average monthly wage," and

42 USC 415.

(2) by inserting immediately before "of (A)" in paragraph (1) the following: "(before the application, in the case of average indexed monthly earnings, of subsection (b)(3)(A))".

Recomputation.

(f)(1) Section 215(f)(2) of this Act is amended to read as follows:

"(2)(A) If an individual has wages or self-employment income for a year after 1978 for any part of which he is entitled to old-age or disability insurance benefits, the Secretary shall, at such time or times and within such period as he may by regulation prescribe, recompute the individual's primary insurance account for that year.

(B) For the purpose of applying subparagraph (A) of subsection (a)(1) to the average indexed monthly earnings of an individual to whom that subsection applies and who receives a recomputation under this paragraph, there shall be used, in lieu of the amounts established by subsection (a)(1)(B) for purposes of clauses (i) and (ii) of subsection (a)(1)(A), the amounts so established that were (or, in the case of an individual described in subsection (a)(4)(B), would have been) used in the computation of such individual's primary insurance amount prior to the application of this subsection.

"(C) A recomputation of any individual's primary insurance amount under this paragraph shall be made as provided in subsection (a)(1) as though the year with respect to which it is made is the last year of the period specified in subsection (b)(2)(B)(ii); and subsection (b)(3)(A) shall apply with respect to any such recomputation as it applied in the computation of such individual's primary insurance amount prior to the application of this subsection.

"(D) A recomputation under this paragraph with respect to any year shall be effective—

"(i) in the case of an individual who did not die in that year, for monthly benefits beginning with benefits for January of the following year; or

"(ii) in the case of an individual who died in that year, for monthly benefits beginning with benefits for the month in which he died.".

(2) Section 215(f)(3) of such Act is repealed.

Repeal.
42 USC 415.

(3) Section 215(f)(4) of such Act is amended to read as follows:

"(4) A recomputation shall be effective under this subsection only if it increases the primary insurance amount by at least $1.".

(4) Section 215(f) of such Act is further amended by adding at the end thereof the following new paragraphs:

"(7) This subsection as in effect in December 1978 shall continue to apply to the recomputation of a primary insurance amount computed under subsection (a) or (d) as in effect (without regard to the table in subsection (a)) in that month, and, where appropriate, under subsection (d) as in effect in December 1977. For purposes of recomputing a primary insurance amount determined under subsection (a) or (d) (as so in effect) in the case of an individual to whom those subsections apply by reason of subsection (a)(4)(B) as in effect after December 1978, no remuneration shall be taken into account for the year in which the individual initially became eligible for an old-age or disability insurance benefit or died, or for any year thereafter.

"(8) The Secretary shall recompute the primary insurance amounts applicable to beneficiaries whose benefits are based on a primary insurance amount which was computed under subsection (a)(3) effective prior to January 1979, or would have been so computed if the dollar amount specified therein were $11.50. Such recomputation shall be effective January 1979, and shall include the effect of the increase in the dollar amount provided by subsection (a)(1)(C)(i)(II). Such primary insurance amount shall be deemed to be provided under such section for purposes of subsection (i).".

Cost-of-living computation quarter.

(g)(1) Section 215(i)(2)(A)(ii) of such Act is amended to read as follows:

"(ii) If the Secretary determines that the base quarter in any year is a cost-of-living computation quarter, he shall, effective with the month of June of that year as provided in subparagraph (B), increase—

"(I) the benefit amount to which individuals are entitled for that month under section 227 or 228,

42 USC 427, 428.

"(II) the primary insurance amount of each other individual on which benefit entitlement is based under this title (including a primary insurance amount determined under subsection (a)(1)(C)(i)(I), but subject to the provisions of such subsection (a)(1)(C)(i) and clauses (iv) and (v) of this subparagraph), and

"(III) the amount of total monthly benefits based on any primary insurance amount which is permitted under section 203 (and such total shall be increased, unless otherwise so increased under another provision of this title, at the same time as such primary insurance amount) or, in the case of a primary insurance amount computed under subsection (a) as in effect (without regard to the table contained therein) prior to January 1979, the amount to which the beneficiaries may be entitled under section 203 as in effect in December 1978, except as provided by section 203(a)(6) and (7) as in effect after December 1978.

Post, p. 1524.

Post, pp. 1526, 1527.

The increase shall be derived by multiplying each of the amounts described in subdivisions (I), (II), and (III) (including each of those amounts as previously increased under this subparagraph) by the same percentage (rounded to the nearest one-tenth of 1 percent) as the percentage by which the Consumer Price Index for that cost-of-living computation quarter exceeds such index for the most recent prior calendar quarter which was a base quarter under paragraph (1)(A)(ii) or, if later, the most recent cost-of-living computation quarter under paragraph (1)(B); and any amount so increased that is not a multiple of $0.10 shall be increased to the next higher multiple of $0.10. Any increase under this subsection in a primary insurance amount determined under subparagraph (C)(i)(II) of subsection (a)(1) shall be applied after the initial determination of such primary insurance amount under that subparagraph (with the amount of such increase, in the case of an individual who becomes eligible for old-age or disability insurance benefits or dies in a calendar year after 1979, being determined from the range of possible primary insurance amounts published by the Secretary under the last sentence of subparagraph (D)).".

42 USC 415.

(2) Section 215(i)(2)(A) of such Act is amended by adding at the end thereof the following new clauses:

"(iii) In the case of an individual who becomes eligible for an old-age or disability insurance benefit, or who dies prior to becoming so eligible, in a year in which there occurs an increase provided under clause (ii), the individual's primary insurance amount (without regard to the time of entitlement to that benefit) shall be increased (unless otherwise so increased under another provision of this title and, with respect to a primary insurance amount determined under subsection (a)(1)(C)(i)(I), subject to the provisions of subsection (a)(1)(C)(i) and clauses (iv) and (v) of this subparagraph) by the amount of that increase and subsequent applicable increases, but only with respect to benefits payable for months after May of that year.

Ante, p. 1514.

"(iv)(I) In the case of an individual who is entitled to an old-age insurance benefit that is based on a primary insurance amount determined under subsection (a)(1)(C)(i)(I), such primary insurance amount shall not be increased under this subsection for any year before the year in which occurs the first month with respect to which there is payable to such individual all or some part of such benefit after application of the provisions of section 203 relating to deductions on account of work, or, if earlier, the year in which he attains age 65.

"(II) In the case of an individual who is entitled to an insurance benefit under subsection (e) or (f) of section 202 that is based on a primary insurance amount determined under subsection (a)(1)(C)(i)(I), such primary insurance amount shall not be increased under this subsection for any year (except as provided in subdivision (III)) before the year in which occurs the first month with respect to which there is payable to such individual all or some part of such benefit after application of the provisions of section 203 relating to deductions on account of work, or, if earlier, the year in which he attains age 65.

42 USC 402.

Ante, p. 1514.

Post, p. 1524.

"(III) Any increase under this subsection which would otherwise be applied to a primary insurance amount except for the provisions of subdivision (II) of this clause, shall apply to such primary insurance amount if, during any month of the year in which the increase occurs, any individual is entitled to a benefit under subsection (d), (g), or (h) of section 202 based on such primary insurance amount, and such primary insurance amount is based upon the wages and self-employment income of a deceased individual.

"(IV) No primary insurance amount determined under subsection (a)(1)(C)(i)(I) shall be increased under this subsection for any year during which no individual was entitled to any benefit based thereon under section 202 or 223 for any month of such year.

Post, pp. 1544, 1547.

"(V) In any case in which an increase under this subsection which occurs during any year applies to a primary insurance amount determined under subsection (a)(1)(C)(i)(I), and such an increase occurring in a later year does not apply to such primary insurance amount on account of the provisions of this clause, any such increase which occurs in a later year which is applicable to such primary insurance amount shall be based upon such primary insurance amount as previously increased under this subsection.

"(v) Notwithstanding clause (iv), no primary insurance amount shall be less than that provided under section 215(a)(1) without regard to subparagraph (C)(i)(I) thereof, as subsequently increased by applicable increases under this section.".

Primary insurance amounts, revision.

Ante, p. 1514.

Publication in Federal Register.

(3) Section 215(i)(2)(D) of such Act (as amended by section 103(d) of this Act) is further amended by striking out all that follows the first sentence and inserting in lieu thereof the following: "He shall also publish in the Federal Register at that time (i) a revision of the range of the primary insurance amounts which are possible after the application of this subsection based on the dollar amount specified in subparagraph (C)(i)(II) of subsection (a)(1) (with such revised primary insurance amounts constituting the increased amounts determined for purposes of such subparagraph (C)(i)(II) under this subsection), or specified in subsection (a)(3) as in effect prior to 1979, and (ii) a revision of the range of maximum family benefits which correspond to such primary insurance amounts (with such maximum benefits being effective notwithstanding section 203(a) except for paragraph (3)(B) thereof (or paragraph (2) thereof as in effect prior to 1979)).".

(4) Section 215(i) of such Act is further amended by adding at the end thereof the following new paragraph:

"(4) This subsection as in effect in December 1978 shall continue to apply to subsections (a) and (d), as then in effect, for purposes of computing the primary insurance amount of an individual to whom subsection (a), as in effect after December 1978, does not apply (including an individual to whom subsection (a) does not apply in any year by reason of paragraph (4)(B) of that subsection (but the application of this subsection in such cases shall be modified by the application of subdivision (I) in the last sentence of paragraph (4) of that subsection)). For purposes of computing primary insurance amounts and maximum family benefits (other than primary insurance amounts and maximum family benefits for individuals to whom such paragraph (4)(B) applies), the Secretary shall publish in the Federal Register revisions of the table of benefits contained in subsection (a), as in effect in December 1978, as required by paragraph (2)(D) of this subsection as then in effect.".

Publication in Federal Register.

MAXIMUM BENEFITS

42 USC 403.

SEC. 202. The text of section 203(a) of the Social Security Act is amended to read as follows:

Ante, p. 1514.
Ante, p. 1519.
Post, pp. 1544, 1547.
Ante, p. 1521.

"(a)(1) In the case of an individual whose primary insurance amount has been computed or recomputed under section 215(a)(1) or (4), or section 215(d), as in effect after December 1978, the total monthly benefits to which beneficiaries may be entitled under section 202 or 223 for a month on the basis of the wages and self-employment income of such individual shall, except as provided by paragraph (3) (but prior to any increases resulting from the application of paragraph (2)(A)(ii)(III) of section 215(i)), be reduced as necessary so as not to exceed—

"(A) 150 percent of such individual's primary insurance amount to the extent that it does not exceed the amount established with respect to this subparagraph by paragraph (2),

"(B) 272 percent of such individual's primary insurance amount to the extent that it exceeds the amount established with respect to subparagraph (A) but does not exceed the amount established with respect to this subparagraph by paragraph (2),

"(C) 134 percent of such individual's primary insurance amount to the extent that it exceeds the amount established with respect to subparagraph (B) but does not exceed the amount established with respect to this subparagraph by paragraph (2), and

"(D) 175 percent of such individual's primary insurance amount to the extent that it exceeds the amount established with respect to subparagraph (C).

Any such amount that is not a multiple of $0.10 shall be increased to the next higher multiple of $0.10.

"(2)(A) For individuals who initially become eligible for old-age or disability insurance benefits, or who die (before becoming so eligible for such benefits), in the calendar year 1979, the amounts established with respect to subparagraphs (A), (B), and (C) of paragraph (1) shall be $230, $332, and $433, respectively.

Ante, p. 1514.

"(B) For individuals who initially become eligible for old-age or disability insurance benefits, or who die (before becoming so eligible for such benefits), in any calendar year after 1979, each of the amounts so established shall equal the product of the corresponding amount established for the calendar year 1979 by subparagraph (A) of this paragraph and the quotient obtained under subparagraph (B)(ii) of section 215(a)(1), with such product being rounded in the manner prescribed by section 215(a)(1)(B)(iii).

Publication in Federal Register.
Ante, p. 1523.

"(C) In each calendar year after 1978 the Secretary shall publish in the Federal Register, on or before November 1, the formula which (except as provided in section 215(i)(2)(D)) is to be applicable under this paragraph to individuals who become eligible for old-age or disability insurance benefits, or who die (before becoming eligible for such benefits), in the following calendar year.

"(D) A year shall not be counted as the year of an individual's death or eligibility for purposes of this paragraph or paragraph (7) in any case where such individual was entitled to a disability insurance benefit for any of the 12 months immediately preceding the month of such death or eligibility (but there shall be counted instead the year of the individual's eligibility for the disability insurance benefits to which he was entitled during such 12 months).

"(3) (A) When an individual who is entitled to benefits on the basis of the wages and self-employment income of any insured individual and to whom this subsection applies would (but for the provisions of section 202(k)(2)(A)) be entitled to child's insurance benefits for a month on the basis of the wages and self-employment income of one or more other insured individuals, the total monthly benefits to which all beneficiaries are entitled on the bases of such wages and self-employment income shall not be reduced under this subsection to less than the smaller of—

42 USC 402.

"(i) the sum of the maximum amounts of benefits payable on the basis of the wages and self-employment income of all such insured individuals, or

"(ii) an amount equal to the product of 1.75 and the primary insurance amount that would be computed under section 215(a)(1) for that month with respect to average indexed monthly earnings equal to one-twelfth of the contribution and benefit base determined for that year under section 230.

Ante, p. 1514.

Ante, p. 1513; *Post*, p. 1554.

"(B) When two or more persons were entitled (without the application of section 202(j)(1) and section 223(b)) to monthly benefits under section 202 or 223 for January 1971 or any prior month on the basis of the wages and self-employment income of such insured individual and the provisions of this subsection as in effect for any such month were applicable in determining the benefit amount of any persons on the basis of such wages and self-employment income, the total of benefits for any month after January 1971 shall not be reduced to less than the largest of—

Post, p. 1542.
42 USC 423.

"(i) the amount determined under this subsection without regard to this subparagraph,

"(ii) the largest amount which has been determined for any month under this subsection for persons entitled to monthly benefits on the basis of such insured individual's wages and self-employment income, or

"(iii) if any persons are entitled to benefits on the basis of such wages and self-employment income for the month before the effective month (after September 1972) of a general benefit increase under this title (as defined in section 215(i)(3)) or a benefit increase under the provisions of section 215(i), an amount equal to the sum of amounts derived by multiplying the benefit amount determined under this title (excluding any part thereof determined under section 202(w)) for the month before such effective month (including this subsection, but without the application of section 222(b), section 202(q), and subsections (b), (c), and (d) of this section), for each such person for such month, by a percentage equal to the percentage of the increase provided under such benefit increase (with any such increased amount which is not a multiple of $0.10 being rounded to the next higher multiple of $0.10);

42 USC 415.
Ante, pp. 1514, 1521.

Post, pp. 1527, 1529.
42 USC 422.
Post, p. 1541.

42 USC 402.

but in any such case (I) subparagraph (A) of this paragraph shall not be applied to such total of benefits after the application of clause (ii) or (iii), and (II) if section 202(k)(2)(A) was applicable in the case of any such benefits for a month, and ceases to apply for a month after such month, the provisions of clause (ii) or (iii) shall be applied, for and after the month in which section 202(k)(2)(A) ceases to apply, as though subparagraph (A) of this paragraph had not been applicable to such total of benefits for the last month for which clause (ii) or (iii) was applicable.

"(C) When any of such individuals is entitled to monthly benefits as a divorced spouse under section 202 (b) or (c) or as a surviving divorced spouse under section 202 (e) or (f) for any month, the benefit to which he or she is entitled on the basis of the wages and self-employment income of such insured individual for such month shall be determined without regard to this subsection, and the benefits of all other individuals who are entitled for such month to monthly benefits under section 202 on the wages and self-employment income of such insured individual shall be determined as if no such divorced spouse or surviving divorced spouse were entitled to benefits for such month.

42 USC 422.

"(4) In any case in which benefits are reduced pursuant to the preceding provisions of this subsection, the reduction shall be made after any deductions under this section and after any deductions under section 222(b). Whenever a reduction is made under this subsection in the total of monthly benefits to which individuals are entitled for any month on the basis of the wages and self-employment income of an insured individual, each such benefit other than the old-age or disability insurance benefit shall be proportionately decreased.

"(5) Notwithstanding any other provision of law, when—

"(A) two or more persons are entitled to monthly benefits for a particular month on the basis of the wages and self-employment income of an insured individual and (for such particular month) the provisions of this subsection are applicable to such monthly benefits, and

"(B) such individual's primary insurance amount is increased for the following month under any provision of this title,

Post, p. 1541.

then the total of monthly benefits for all persons on the basis of such wages and self-employment income for such particular month, as determined under the provisions of this subsection, shall for purposes of determining the total monthly benefits for all persons on the basis of such wages and self-employment income for months subsequent to such particular month be considered to have been increased by the smallest amount that would have been required in order to assure that the total of monthly benefits payable on the basis of such wages and self-employment income for any such subsequent month will not be less (after the application of the other provisions of this subsection and section 202(q)) than the total of monthly benefits (after the application of the other provisions of this subsection and section 202(q)) payable on the basis of such wages and self-employment income for such particular month.

Ante, pp. 1514, 1519.

"(6) In the case of any individual who is entitled for any month to benefits based upon the primary insurance amounts of two or more insured individuals, one or more of which primary insurance amounts were determined under section 215(a) or 215(d) as in effect (without regard to the table contained therein) prior to January 1979 and one or more of which primary insurance amounts were determined under section 215(a) (1) or (4), or section 215(d), as in effect after December 1978, the total benefits payable to that individual and all other individuals entitled to benefits for that month based upon those primary insurance amounts shall be reduced to an amount equal to the product of 1.75 and the primary insurance amount that would be computed under section 215(a) (1) for that month with respect to average indexed monthly earnings equal to one-twelfth of the contribution and benefits base determined under section 230 for the year in which that month occurs.

Ante, pp. 1514, 1520.

Ante, p. 1513; *Post*, p. 1554.

"(7) Subject to paragraph (6), this subsection as in effect in December 1978 shall remain in effect with respect to a primary insurance amount computed under section 215 (a) or (d), as in effect (without regard to the table contained therein) in December 1978, except that a primary insurance amount so computed with respect to an individual who first becomes eligible for an old-age or disability insurance benefit, or dies (before becoming eligible for such a benefit), after December 1978, shall instead be governed by this section as in effect after December 1978.".

INCREASE IN OLD-AGE BENEFIT AMOUNTS FOR DELAYED RETIREMENT

SEC. 203. Section 202(w)(1) of Social Security Act is amended—

42 USC 402.

(1) by striking out "If the first month" and all that follows down through "to such individual" in the matter preceding subparagraph (A) and inserting in lieu thereof "The amount of an old-age insurance benefit (other than a benefit based on a primary insurance amount determined under section 215(a)(3)) which is payable without regard to this subsection to an individual"; and

Ante, p. 1514.

(2) by inserting after "such amount," in subparagraph (A) the following: "or, in the case of an individual who first becomes eligible for an old-age insurance benefit after December 1978, one-quarter of 1 percent of such amount,".

WIDOW'S AND WIDOWER'S INSURANCE BENEFITS IN CASES OF DELAYED RETIREMENT

SEC. 204. (a) Section 202(e)(2)(A) of the Social Security Act is amended (1) by inserting "(as determined after application of the following sentence)" after "primary insurance amount", and (2) by adding at the end thereof the following new sentence: "If such deceased individual was (or upon application would have been) entitled to an old-age insurance benefit which was increased (or subject to being increased) on account of delayed retirement under the provisions of subsection (w), then, for purposes of this subsection, such individual's primary insurance amount, if less than the old-age insurance benefit (increased, where applicable, under section 215(f) (5) or (6) and under section 215(i) as if such individual were still alive in the case of an individual who has died) which he was receiving (or would upon application have received) for the month prior to the month in which he died, shall be deemed to be equal to such old-age insurance benefit, and (notwithstanding the provisions of paragraph (3) of such subsection (w) the number of increment months shall include any month in the months of the calendar year in which he died, prior to the month in which he died, which satisfy the conditions in paragraph (2) of such subsection (w).".

Post, p. 1545.

Supra.

42 USC 415.

Ante, pp. 1514, 1521.

42 USC 402.
42 USC 415.

(b) Section 202(e)(2)(B)(i) of such Act is amended by inserting "and section 215(f) (5) or (6) were applied, where applicable," after "living".

Post, pp. 1546, 1547.
42 USC 402.
42 USC 415.
Ante, pp. 1514, 1521.

(c) Section 202(f)(3)(A) of such Act is amended (1) by inserting "(as determined after application of the following sentence)" after "primary insurance amount", and (2) by adding at the end thereof the following new sentence: "If such deceased individual was (or upon application would have been) entitled to an old-age insurance benefit which was increased (or subject to being increased) on account of delayed retirement under the provisions of subsection (w), then, for purposes of this subsection, such individual's primary insurance amount, if less than the old-age insurance benefit (increased, where applicable, under section 215(f) (5) or (6) and under section 215(i) as if such individual were still alive in the case of an individual who has died) which she was receiving (or would upon application have received) for the month prior to the month in which she died, shall be deemed to be equal to such old-age insurance benefit, and (notwithstanding the provisions of paragraph (3) of such subsection (w)) the number of increment months shall include any month in the months of the calendar year in which she died, prior to the month in which she died, which satisfy the conditions in paragraph (2) of such subsection (w).".

42 USC 402.

(d) Section 202 (f)(3)(B)(i) of such Act is amended by inserting "and section 215(f) (5) or (6) were applied, where applicable," after "living".

Ante, p. 1524.

(e) Section 203(a) of such Act (as amended by section 202 of this Act) is further amended by adding at the end thereof the following new paragraph:

"(8) When—

Post, p. 1542.

"(A) one or more persons were entitled (without the application of section 202(j)(1)) to monthly benefits under section 202 for May 1978 on the basis of the wages and self-employment income of an individual,

"(B) the benefit of at least one such person for June 1978 is increased by reason of the amendments made by section 204 of the Social Security Amendments of 1977; and

42 USC 402.
Ante, p. 1526.

"(C) the total amount of benefits to which all such persons are entitled under such section 202 are reduced under the provisions of this subsection (or would be so reduced except for the first sentence of section 203(a)(4)),

Supra.

then the amount of the benefit to which each such person is entitled for months after May 1978 shall be increased (after such reductions are made under this subsection) to the amount such benefits would have been if the benefit of the person or persons referred to in subparagraph (B) had not been so increased.".

CONFORMING AMENDMENTS

42 USC 402.

SEC. 205. (a) Section 202(m)(1) of the Social Security Act is amended to read as follows:

Ante, pp. 1514, 1520.

"(1) In any case in which an individual is entitled to a monthly benefit under this section on the basis of a primary insurance amount computed under section 215 (a) or (d), as in effect after December 1978, on the basis of the wages and self-employment income of a deceased individual for any month and no other person is (without the application of subsection (j)(1)) entitled to a monthly benefit under this section for that month on the basis of such wages and self-employment income, the individual's benefit amount for that month, prior to reduction under subsection (k)(3), shall not be less than that provided by subparagraph (C)(i)(I) of section 215(a)(1) and increased under section 215(i) for months after May of the year in which the insured individual died as though such benefit were a primary insurance amount.". *Post*, p. 1542.

(b) Section 202(w) of such Act (as amended by section 203 of this Act) is further amended— *Ante*, p. 1527.

(1) by inserting after "section 215(a)(3)" in paragraph (1) (in the matter preceding subparagraph (A)) the following: "as in effect in December 1978 or section 215(a)(1)(C)(i)(II) as in effect thereafter"; *Ante*, p. 1514.

(2) by inserting "as in effect in December 1978, or section 215(a)(1)(C)(i)(II) as in effect thereafter," after "paragraph (3) of section 215(a)" in paragraph (5); and

(3) by inserting "(whether before, in, or after December 1978)" after "determined under section 215(a)" in paragraph (5).

(c) Section 217(b)(1) of such Act is amended by inserting "as in effect in December 1978" after "section 215(c)" each place it appears, and after "section 215(d)". 42 USC 417.

(d) Section 224(a) of such Act is amended by inserting "(determined under section 215(b) as in effect prior to January 1979)" after "(A) the average monthly wage" in the sentence immediately following paragraph (8). *Post*, p. 1553. 42 USC 424.

(e) Section 1839(c)(3)(B) of such Act is amended to read as follows: 42 USC 1395r.

"(B) the monthly premium rate most recently promulgated by the Secretary under this paragraph, increased by a percentage determined as follows: The Secretary shall ascertain the primary insurance amount computed under section 215(a)(1), based upon average indexed monthly earnings of $900, that applied to individuals who became eligible for and entitled to old-age insurance benefits on May 1 of the year of the promulgation. He shall increase the monthly premium rate by the same percentage by which that primary insurance amount is increased when, by reason of the law in effect at the time the promulgation is made, it is so computed to apply to those individuals on the following May 1.".

EFFECTIVE DATE

SEC. 206. The amendments made by the provisions of this title other than sections 201(d), 204, and 205(a) shall be effective with respect to monthly benefits under title II of the Social Security Act payable for months after December 1978 and with respect to lump-sum death payments with respect to deaths occurring after such month. The amendments made by section 201(d) shall be effective with respect to monthly benefits of an individual who becomes eligible for an old-age or disability insurance benefit, or dies, after December 1977. The amendments made by section 204 shall be effective with respect to monthly benefits for months after May 1978. The amendment made by section 205(a) shall be effective with respect to monthly benefits payable for months after December 1978 based on the wages and self-employment income of individuals who die after December 1978. 42 USC 402 note. 42 USC 401.

TITLE III—OTHER CHANGES IN PROVISIONS RELATING TO THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE PROGRAM

PART A—CHANGES IN EARNINGS TEST

LIBERALIZATION OF EARNINGS TEST FOR INDIVIDUALS AGE 65 AND OVER

42 USC 403.

SEC. 301. (a) Section 203(f)(8)(A) of the Social Security Act is amended by striking out "a new exempt amount which shall be effective (unless such new exempt amount is prevented from becoming effective by subparagraph (C) of this paragraph) with respect to any individual's taxable year which ends after the calendar year" and inserting in lieu thereof "the new exempt amounts (separately stated for individuals described in subparagraph (D) and for other individuals) which are to be applicable (unless prevented from becoming effective by subparagraph (C)) with respect to taxable years ending in (or with the close of) the calendar year after the calendar year".

(b)(1) Section 203(f)(8)(B) of such Act is amended by striking out "The exempt amount for each month of a particular taxable year shall be" in the matter preceding clause (i) and inserting in lieu thereof "Except as otherwise provided in subparagraph (D), the exempt amount which is applicable to individuals described in such subparagraph and the exempt amount which is applicable to other individuals, for each month of a particular taxable year, shall each be".

Post, p. 1552.

(2) Section 203(f)(8)(B)(i) of such Act is amended by striking out "the exempt amount" and inserting in lieu thereof "the corresponding exempt amount".

(3) The last sentence of section 203(f)(8)(B) of such Act is amended by striking out "the exempt amount" and inserting in lieu thereof "an exempt amount".

(c)(1) Section 203(f)(8) of such Act is further amended by adding at the end thereof the following new subparagraph:

"(D) Notwithstanding any other provision of this subsection, the exempt amount which is applicable to an individual who has attained age 65 before the close of the taxable year involved—

"(i) shall be $333.33⅓ for each month of any taxable year ending after 1977 and before 1979,

"(ii) shall be $375 for each month of any taxable year ending after 1978 and before 1980,

"(iii) shall be $416.66⅔ for each month of any taxable year ending after 1979 and before 1981,

"(iv) shall be $458.33⅓ for each month of any taxable year ending after 1980 and before 1982, and

"(v) shall be $500 for each month of any taxable year ending after 1981 and before 1983.".

42 USC 403 note.

Supra.

Supra.

Supra.

(2) No notification with respect to an increased exempt amount for individuals described in section 203(f)(8)(D) of the Social Security Act (as added by paragraph (1) of this subsection) shall be required under the last sentence of section 203(f)(8)(B) of such Act in 1977, 1978, 1979, 1980, or 1981; and section 203(f)(8)(C) of such Act shall not prevent the new exempt amount determined and published under section 203(f)(8)(A) in 1977 from becoming effective to the extent that such new exempt amount applies to individuals other than those described in section 203(f)(8)(D) of such Act (as so added).

(d) Subsections (f)(1), (f)(3), (f)(4)(B), and (h)(1)(A) of section 203 of such Act are each amended by striking out "$200 or the exempt amount" and inserting in lieu thereof "the applicable exempt amount".

(e) The amendments made by this section shall apply with respect to taxable years ending after December 1977.

Effective date.
42 USC 403 note.

REPEAL OF EARNINGS LIMITATION FOR INDIVIDUALS AGE 70 AND OVER

SEC. 302. (a) Subsections (c)(1), (d)(1), (f)(1)(B), and (j) of section 203 of the Social Security Act are each amended by striking out "seventy-two" and inserting in lieu thereof "seventy".

42 USC 403.

(b) Subsection (f)(3) of section 203 of such Act is amended by striking out "age 72" and inserting in lieu thereof "age 70".

(c) Subsection (h)(1)(A) of section 203 of such Act is amended by striking out "the age of 72" and "age 72" and inserting in lieu thereof in each instance "age 70".

(d) The heading of subsection (j) of section 203 of such Act is amended by striking out "Seventy-two" and inserting in lieu thereof "Seventy".

(e) The amendments made by this section shall apply only with respect to taxable years ending after December 31, 1981.

Effective date.
42 USC 403 note.

ELIMINATION OF MONTHLY EARNINGS TEST

SEC. 303. (a) Clause (E) of the last sentence of section 203(f)(1) of the Social Security Act (as amended by section 301(d) of this Act) is further amended by inserting before the period at the end thereof the following: ", if such month is in the taxable year in which occurs the first month that is both (i) a month for which the individual is entitled to benefits under subsection (a), (b), (c), (d), (e), (f), (g), or (h) of section 202 (without having been entitled for the preceding month to a benefit under any other of such subsections), and (ii) a month in which the individual did not engage in self-employment and did not render services for wages (determined as provided in paragraph (5)) of more than the applicable exempt amount as determined under paragraph (8)".

Ante, p. 1530.
42 USC 402.

(b) The amendment made by subsection (a) shall apply only with respect to monthly benefits payable for months after December 1977.

Effective date.
42 USC 403 note.

PART B—COVERAGE

STUDY OF UNIVERSAL COVERAGE

SEC. 311. (a) The Secretary of Health, Education, and Welfare is directed to undertake, as soon as possible after the date of the enactment of this Act, a thorough study with respect to the extent of the coverage under the old-age, survivors, and disability insurance programs and under the programs established by title XVIII of the Social Security Act. The study shall examine the feasibility and desirability of covering, under such social security programs, Federal employees, State and local governmental employees, and employees of non-profit organizations who are not now covered. The study shall include alternative methods of accomplishing such coverage together with any appropriate alternatives to extending coverage to such employees.

42 USC 902 note.
42 USC 1395.

(b) With respect to each major alternative method or proposal included in the study described in subsection (a), such study shall also include an analysis of the changes which would be required in the programs established by the Social Security Act and in any other systems or programs (such as retirement, survivorship, disability, and health

42 USC 1305.

programs) affecting the individuals who would be covered under such social security programs under such alternative method or proposal. Such analysis shall include the structural changes required in such programs, the financial impact of such changes, and the effect of such changes on the benefit rights and contribution liabilities of the affected individuals.

Consultation.

(c) In conducting the study required by subsection (a), the Secretary of Health, Education, and Welfare shall consult, as appropriate, with the Secretary of the Treasury, the Director of the Office of Management and Budget, and the Chairman of Civil Service Commission, and those officials shall provide him with such information and assistance as he may require. The Secretary shall also solicit the views of other appropriate officials and organizations.

Report to President and Congress. Legislative recommendations.

(d) The Secretary of Health, Education, and Welfare shall submit to the President and the Congress, not later than 2 years after the date of the enactment of this Act, a report of the findings of the study required by subsection (a) together with his recommendations for any appropriate legislative changes.

COVERAGE OF NONPROFIT ORGANIZATIONS WHICH FAILED TO FILE WAIVER CERTIFICATES

26 USC 3121.

SEC. 312. (a) (1) Section 3121 (k) (5) of the Internal Revenue Code of 1954 (relating to constructive filing of certificate where refund or credit has been made and new certificate is not filed) is amended—

(A) by striking out "prior to the expiration of 180 days after the date of the enactment of this paragraph," in subparagraph (B) and inserting in lieu thereof "prior to April 1, 1978,"; and

(B) by striking out "the 181st day after the date of the enactment of this paragraph," and "such 181st day" in the matter following subparagraph (B) and inserting in lieu thereof in each instance "April 1, 1978,".

(2) Section 3121(k) (7) of such Code (relating to payment of both employee and employer taxes for retroactive period by organization in cases of constructive filing) is amended—

(A) by striking out "prior to the expiration of 180 days after the date of the enactment of this paragraph" and inserting in lieu thereof "prior to April 1, 1978,";

(B) by striking out "the 181st day after such date," and inserting in lieu thereof "April 1, 1978,"; and

(C) by striking out "prior to the first day of the calendar quarter in which such 181st day occurs" and inserting in lieu thereof "prior to that date".

(3) Section 3121(k) (8) of such Code (relating to extended period for payment of taxes for retroactive coverage) is amended—

(A) by striking out "by the end of the 180-day period following the date of the enactment of this paragraph" and inserting in lieu thereof "prior to April 1, 1978,";

(B) by striking out "within that period" and inserting in lieu thereof "prior to April 1, 1978"; and

(C) by striking out "on the 181st day following that date" and inserting in lieu thereof "on that date".

(b) (1) Section 3121(k) (4) of such Code (relating to constructive filing of certificate where no refund or credit of taxes has been made) is amended by adding at the end thereof the following new subparagraph:

"(C) In the case of any organization which is deemed under this paragraph to have filed a valid waiver certificate under paragraph (1), if—

Waiver certificate, filing.

"(i) the period with respect to which the taxes imposed by sections 3101 and 3111 were paid by such organization (as described in subparagraph (A)(ii)) terminated prior to October 1, 1976, or

Ante, p. 1510; *Post*, p. 1540. *Ante*, p. 1512; *Post*, pp. 1537, 1540.

"(ii) the taxes imposed by sections 3101 and 3111 were not paid during the period referred to in clause (i) (whether such period has terminated or not) with respect to remuneration paid by such organization to individuals who became its employees after the close of the calendar quarter in which such period began,

taxes under sections 3101 and 3111—

"(iii) in the case of an organization which meets the requirements of this subparagraph by reason of clause (i), with respect to remuneration paid by such organization after the termination of the period referred to in clause (i) and prior to July 1, 1977; or

"(iv) in the case of an organization which meets the requirements of this subparagraph by reason of clause (ii), with respect to remuneration paid prior to July 1, 1977, to individuals who became its employees after the close of the calendar quarter in which the period referred to in clause (i) began,

which remain unpaid on the date of the enactment of this subparagraph, or which were paid after October 19, 1976, but prior to the date of the enactment of this subparagraph, shall not be due or payable (or, if paid, shall be refunded); and the certificate which such organization is deemed under this paragraph to have filed shall not apply to any service with respect to the remuneration for which the taxes imposed by sections 3101 and 3111 (which remain unpaid on the date of the enactment of this subparagraph, or were paid after October 19, 1976, but prior to the date of the enactment of this subparagraph) are not due and payable (or are refunded) by reason of the preceding provisions of this subparagraph. In applying this subparagraph for purposes of title II of the Social Security Act, the period during which reports of wages subject to the taxes imposed by sections 3101 and 3111 were made by any organization may be conclusively treated as the period (described in subparagraph (A)(ii)) during which the taxes imposed by such sections were paid by such organization.".

42 USC 401.

(2) Section 3121(k)(4)(A) of such Code is amended by inserting "(subject to subparagraph (C))" after "effective" in the matter following clause (ii).

26 USC 3121.

(3) Section 3121(k)(6) of such Code (relating to application of certain provisions to cases of constructive filing) is amended by inserting "(except as provided in paragraph (4)(C))" after "services involved" in the matter preceding subparagraph (A).

(4) Section 3121(k)(4) of such Code is amended by striking out "date" in subparagraph (B)(ii) and inserting in lieu thereof "first day of the calendar quarter".

(c) In any case where—

26 USC 3121 note.

(1) an individual performed service, as an employee of an organization which is deemed under section 3121(k)(4) of the

26 USC 1402.

(b) Section 1402(a) of the Internal Revenue Code of 1954 (relating to definition of net earnings from self-employment) is amended—

(1) by striking out "and" at the end of paragraph (10);

(2) by striking out the period at the end of paragraph (11) and inserting in lieu thereof "; and"; and

(3) by inserting after paragraph (11) the following new paragraph:

26 USC 707.

"(12) there shall be excluded the distributive share of any item of income or loss of a limited partner, as such, other than guaranteed payments described in section 707(c) to that partner for services actually rendered to or on behalf of the partnership to the extent that those payments are established to be in the nature of remuneration for those services.".

Effective date.
42 USC 411 note.

(c) The amendments made by this section shall apply with respect to taxable years beginning after December 31, 1977.

EMPLOYEES OF MEMBERS OF RELATED GROUPS OF CORPORATIONS

26 USC 3121.
26 USC 3101–3126.

Sec. 314. (a) Section 3121 of the Internal Revenue Code of 1954 (definitions for purposes of the Federal Insurance Contributions Act) is amended by adding at the end thereof the following new subsection:

Post, p. 1555.
Ante, p. 1511;
Post, pp. 1537, 1540.

"(s) Concurrent Employment by Two or More Employers.—For purposes of sections 3102, 3111, and 3121(a)(1), if two or more related corporations concurrently employ the same individual and compensate such individual through a common paymaster which is one of such corporations, each such corporation shall be considered to have paid as remuneration to such individual only the amounts actually disbursed by it to such individual and shall not be considered to have paid as remuneration to such individual amounts actually disbursed to such individual by another of such corporations.".

26 USC 3306.

(b) Section 3306 of such Code (relating to definitions in respect of unemployment tax) is amended by adding at the end thereof the following new subsection:

26 USC 3301, 3302.

"(p) Concurrent Employment by Two or More Employers.—For purposes of sections 3301, 3302, and 3306(b)(1), if two or more related corporations concurrently employ the same individual and compensate such individual through a common paymaster which is one of such corporations, each such corporation shall be considered to have paid as remuneration to such individual only the amounts actually disbursed by it to such individual and shall not be considered to have paid as remuneration to such individual amounts actually disbursed to such individual by another of such corporations.".

Effective date.
26 USC 3121 note.

(c) The amendments made by this section shall apply with respect to wages paid after December 31, 1978.

TAX ON EMPLOYERS OF INDIVIDUALS WHO RECEIVE INCOME FROM TIPS

Supra.

Sec. 315. (a) Section 3121 of the Internal Revenue Code of 1954 (definitions for purposes of the Federal Insurance Contributions Act) is amended by adding at the end thereof (after the new subsection added by section 314(a) of this Act) the following new subsection:

Post, p. 1555.

"(t) Special Rule for Determining Wages Subject to Employer Tax in Case of Certain Employers Whose Employees Receive Income From Tips.—If the wages paid by an employer with respect to the employment during any month of an individual who (for services performed in connection with such employment) receives tips which constitute wages, and to which section 3102(a) applies, are less than the total amount which would be payable (with respect to such employment) at the minimum wage rate applicable to such individual under section 6(a)(1) of the Fair Labor Standards Act of 1938 (determined without regard to section 3(m) of such Act), the wages so paid shall be deemed for purposes of section 3111 to be equal to such total amount.".

Ante, p. 1245.
29 USC 203.

(b) Section 3111 of such Code is amended by inserting "and (t)" after "3121(a)" in subsections (a) and (b).

Ante, pp. 1511, 1512.

(c) The amendments made by this section shall apply with respect to wages paid with respect to employment performed in months after December 1977.

Effective date.
26 USC 3111 note.

REVOCATION OF EXEMPTION FROM COVERAGE BY CLERGYMEN

SEC. 316. (a) Notwithstanding section 1402(e)(3) of the Internal Revenue Code of 1954, any exemption which has been received under section 1402(e)(1) of such Code by a duly ordained, commissioned, or licensed minister of a church or a Christian Science practitioner, and which is effective for the taxable year in which this Act is enacted, may be revoked by filing an application therefor (in such form and manner, and with such official, as may be prescribed in regulations made under chapter 2 of such Code), if such application is filed—

26 USC 1402 note.
26 USC 1402.
26 USC 1401.

(1) before the applicant becomes entitled to benefits under section 202(a) or 223 of the Social Security Act (without regard to section 202(j)(1) or 223(b) of such Act), and

42 USC 402, 423.

(2) no later than the due date of the Federal income tax return (including any extension thereof) for the applicant's first taxable year beginning after the date of the enactment of this Act.

Post, p. 1542.

Any such revocation shall be effective (for purposes of chapter 2 of the Internal Revenue Code of 1954 and title II of the Social Security Act), as specified in the application, either with respect to the applicant's first taxable year ending on or after the date of the enactment of this Act or with respect to the applicant's first taxable year beginning after such date, and for all succeeding taxable years; and the applicant for any such revocation may not thereafter again file application for an exemption under such section 1402(e)(1). If the application is filed on or after the due date of the applicant's first taxable year ending on or after the date of the enactment of this Act and is effective with respect to that taxable year, it shall include or be accompanied by payment in full of an amount equal to the total of the taxes that would have been imposed by section 1401 of the Internal Revenue Code of 1954 with respect to all of the applicant's income derived in that taxable year which would have constituted net earnings from self-employment for purposes of chapter 2 of such Code (notwithstanding section 1402(c)(4) or (c)(5) of such Code) except for the exemption under section 1402(e)(1) of such Code.

42 USC 401.
26 USC 1401.

(b) Subsection (a) shall apply with respect to service performed (to the extent specified in such subsection) in taxable years ending on or after the date of the enactment of this Act, and with respect to monthly insurance benefits payable under title II of the Social Security Act on the basis of the wages and self-employment income of any individual for months in or after the calendar year in which such individual's application for revocation (as described in such subsection) is filed (and lump-sum death payments payable under such title on the basis of such wages and self-employment income in the case of deaths occurring in or after such calendar year).

42 USC 401.

INTERNATIONAL AGREEMENTS WITH RESPECT TO SOCIAL SECURITY BENEFITS

SEC. 317. (a) Title II of the Social Security Act is amended by adding at the end thereof the following new section:

"INTERNATIONAL AGREEMENTS

"Purpose of Agreement

42 USC 433.

"SEC. 233. (a) The President is authorized (subject to the succeeding provisions of this section) to enter into agreements establishing totalization arrangements between the social security system established by this title and the social security system of any foreign country, for the purposes of establishing entitlement to and the amount of old-age, survivors, disability, or derivative benefits based on a combination of an individual's periods of coverage under the social security system established by this title and the social security system of such foreign country.

"Definitions

"(b) For the purposes of this section—

"(1) the term 'social security system' means, with respect to a foreign country, a social insurance or pension system which is of general application in the country and under which periodic benefits, or the actuarial equivalent thereof, are paid on account of old age, death, or disability; and

"(2) the term 'period of coverage' means a period of payment of contributions or a period of earnings based on wages for employment or on self-employment income, or any similar period recognized as equivalent thereto under this title or under the social security system of a country which is a party to an agreement entered into under this section.

"Crediting Periods of Coverage; Conditions of Payment of Benefits

"(c) (1) Any agreement establishing a totalization arrangement pursuant to this section shall provide—

Post, pp. 1550, 1552.

"(A) that in the case of an individual who has at least 6 quarters of coverage as defined in section 213 of this Act and periods of coverage under the social security system of a foreign country which is a party to such agreement, periods of coverage of such individual under such social security system of such foreign country may be combined with periods of coverage under this title and otherwise considered for the purposes of establishing entitlement to and the amount of old-age, survivors, and disability insurance benefits under this title;

"(B) (i) that employment or self-employment, or any service which is recognized as equivalent to employment or self-employment under this title or the social security system of a foreign country which is a party to such agreement, shall, on or after the effective date of such agreement, result in a period of coverage under the system established under this title or under the system established under the laws of such foreign country, but not under both, and (ii) the methods and conditions for determining under which system employment, self-employment, or other service shall result in a period of coverage; and

"(C) that where an individual's periods of coverage are combined, the benefit amount payable under this title shall be based on the proportion of such individual's periods of coverage which was completed under this title.

"(2) Any such agreement may provide that—

"(A) an individual who is entitled to cash benefits under this title shall, notwithstanding the provisions of section 202(t), receive such benefits while he resides in a foreign country which is a party to such agreement; and

42 USC 402.

"(B) the benefit paid by the United States to an individual who legally resides in the United States shall, if less when added to the benefit paid by such foreign country than the benefit amount which would be payable to an entitled individual based on the first figure in (or deemed to be in) column IV of the table in section 215(a) in the case of an individual becoming eligible for such benefit before January 1, 1979, or based on a primary insurance amount determined under section 215(a)(1)(C)(i)(I) in the case of an individual becoming eligible for such benefit on or after that date, be increased so that the total of the two benefits is equal to the benefit amount which would be so payable.

Ante, p. 1514.

"(3) Section 226 shall not apply in the case of any individual to whom it would not be applicable but for this section or any agreement or regulation under this section.

Post, pp. 1543, 1546.

"(4) Any such agreement may contain other provisions which are not inconsistent with the other provisions of this title and which the President deems appropriate to carry out the purposes of this section.

"Regulations

"(d) The Secretary of Health, Education, and Welfare shall make rules and regulations and establish procedures which are reasonable and necessary to implement and administer any agreement which has been entered into in accordance with this section.

"Reports to Congress; Effective Date of Agreements

"(e)(1) Any agreement to establish a totalization arrangement entered into pursuant to this section shall be transmitted by the President to the Congress together with a report on the estimated number of individuals who will be affected by the agreement and the effect of the agreement on the estimated income and expenditures of the programs established by this Act.

"(2) Such an agreement shall become effective on any date, provided in the agreement, which occurs after the expiration of the period (following the date on which the agreement is transmitted in accordance with paragraph (1)) during which each House of the Congress has been in session on each of 90 days; except that such agreement shall not become effective if, during such period, either House of the Congress adopts a resolution of disapproval of the agreement.".

(b)(1) Section 1401 of the Internal Revenue Code of 1954 is amended by adding at the end thereof the following new subsection:

26 USC 1401.

"(c) RELIEF FROM TAXES IN CASES COVERED BY CERTAIN INTERNATIONAL AGREEMENTS.—During any period in which there is in effect an agreement entered into pursuant to section 233 of the Social Security Act with any foreign country, the self-employment income of an individual shall be exempt from the taxes imposed by this section to the extent that such self-employment income is subject under such agree-

Ante, p. 1538.

ment to taxes or contributions for similar purposes under the social security system of such foreign country.".

26 USC 3101, 3111.

(2) Sections 3101 and 3111 of such Code are each amended by adding at the end thereof the following new subsection:

"(c) Relief From Taxes in Cases Covered by Certain International Agreements.—During any period in which there is in effect an agreement entered into pursuant to section 233 of the Social Security Act with any foreign country, wages received by or paid to an individual shall be exempt from the taxes imposed by this section to the extent that such wages are subject under such agreement to taxes or contributions for similar purposes under the social security system of such foreign country.".

Ante, p. 1538.

26 USC 6051.

(3) Section 6051(a) of such Code is amended by adding at the end thereof the following new sentence: "The amounts required to be shown by paragraph (5) shall not include wages which are exempted pursuant to sections 3101(c) and 3111(c) from the taxes imposed by sections 3101 and 3111.".

Supra.

26 USC 1401 note.

(4) Notwithstanding any other provision of law, taxes paid by any individual to any foreign country with respect to any period of employment or self-employment which is covered under the social security system of such foreign country in accordance with the terms of an agreement entered into pursuant to section 233 of the Social Security Act shall not, under the income tax laws of the United States, be deductible by, or creditable against the income tax of, any such individual.

MODIFICATION OF AGREEMENT WITH ILLINOIS TO PROVIDE COVERAGE FOR CERTAIN POLICEMEN AND FIREMEN

42 USC 418 note.
42 USC 418.

Sec. 318. (a) Notwithstanding the provisions of subsection (d)(5)(A) of section 218 of the Social Security Act and the references thereto in subsections (d)(1) and (d)(3) of such section 218, the agreement with the State of Illinois heretofore entered into pursuant to such section 218 may, at any time prior to January 1, 1979, be modified pursuant to subsection (c)(4) of such section 218 so as to apply to services performed in policemen's or firemen's positions covered by the Illinois Municipal Retirement Fund on the date of the enactment of this Act if the State of Illinois has at any time prior to the date of the enactment of this Act paid to the Secretary of the Treasury, with respect to any of the services performed in such positions, the sums prescribed pursuant to subsection (e)(1) of such section 218. For purposes of this section, a retirement system which covers positions of policemen or firemen shall, if the State of Illinois so desires, be deemed to be a separate retirement system with respect to the positions of such policemen or firemen, as the case may be.

(b) Notwithstanding the provisions of subsection (f) of section 218 of the Social Security Act, any modification in the agreement with the State of Illinois under subsection (a) of this section, to the extent that it involves services performed by a policeman or fireman in positions covered under the Illinois Municipal Retirement Fund, shall be made effective with respect to—

(1) all services performed by policemen or firemen, in positions to which the modification relates, on or after the date of the enactment of this Act; and

(2) all services performed by such individuals in such positions before such date of enactment with respect to which the State of Illinois has paid to the Secretary of the Treasury the sums pre-

scribed pursuant to subsection (e)(1) of such section 218 at the time or times established pursuant to such subsection (e)(1), if and to the extent that— 42 USC 418.

(A) no refund of the sums so paid has been obtained, or

(B) a refund of part or all of the sums so paid has been obtained but the State of Illinois repays to the Secretary of the Treasury the amount of such refund within 90 days after the date that the modification is agreed to by the State and the Secretary of Health, Education, and Welfare.

COVERAGE FOR POLICEMEN AND FIREMEN IN MISSISSIPPI

SEC. 319. Section 218(p)(1) of the Social Security Act is amended by inserting "Mississippi," after "Maryland,". 42 USC 418.

COVERAGE UNDER DIVIDED RETIREMENT SYSTEM FOR PUBLIC EMPLOYEES IN NEW JERSEY

SEC. 320. Section 218(d)(6)(C) of the Social Security Act is amended by inserting "New Jersey," after "Nevada,".

COVERAGE OF SERVICE UNDER WISCONSIN RETIREMENT SYSTEM

SEC. 321. Section 218(m)(1) of the Social Security Act is amended by inserting after "Wisconsin retirement fund" the following: "or any successor system".

PART C—BENEFIT AMOUNTS AND ELIGIBILITY

ACTUARIAL REDUCTION OF BENEFIT INCREASES TO BE APPLIED AS OF TIME OF ORIGINAL ENTITLEMENT

SEC. 331. (a) Section 202(q)(4) of the Social Security Act is amended by striking out all that follows subparagraph (B) and inserting in lieu thereof the following: 42 USC 402.

"then the amount of the reduction of such benefit (after the application of any adjustment under paragraph (7)) for each month beginning with the month of such increase in the primary insurance amount shall be computed under paragraph (1) or (3), whichever applies, as though the increased primary insurance amount had been in effect for and after the month for which the individual first became entitled to such monthly benefit reduced under such paragraph (1) or (3).".

(b) Section 202(q) of such Act is further amended by adding at the end thereof the following new paragraphs:

"(10) For purposes of applying paragraph (4), with respect to monthly benefits payable for any month after December 1977 to an individual who was entitled to a monthly benefit as reduced under paragraph (1) or (3) prior to January 1978, the amount of reduction in such benefit for the first month for which such benefit is increased by reason of an increase in the primary insurance amount of the individual on whose wages and self-employment income such benefit is based and for all subsequent months (and similarly for all subsequent increases) shall be increased by a percentage equal to the percentage increase in such primary insurance amount (such increase being made in accordance with the provisions of paragraph (8)). In the case of an individual whose reduced benefit under this section is increased as a result of the use of an adjusted reduction period or an additional adjusted reduction period (in accordance with paragraphs (1) and (3) of this subsection), then for the first month for which such increase is effective, and for all subsequent months, the amount of such reduction (after the application of the previous sentence, if applicable) shall be determined—

"(A) in the case of old-age, wife's, and husband's insurance benefits, by multiplying such amount by the ratio of (i) the number of months in the adjusted reduction period to (ii) the number of months in the reduction period,

"(B) in the case of widow's and widower's insurance benefits for the month in which such individual attains age 62, by multiplying such amount by the ratio of (i) the number of months in the reduction period beginning with age 62 multiplied by $^{19}/_{40}$ of 1 percent, plus the number of months in the adjusted reduction period prior to age 62 multiplied by $^{19}/_{40}$ of 1 percent, plus the number of months in the adjusted additional reduction period multiplied by $^{43}/_{240}$ of 1 percent to (ii) the number of months in the reduction period multiplied by $^{19}/_{40}$ of 1 percent, plus the number of months in the additional reduction period multiplied by $^{43}/_{240}$ of 1 percent, and

"(C) in the case of widow's and widower's insurance benefits for the month in which such individual attains age 65, by multiplying such amount by the ratio of (i) the number of months in the adjusted reduction period multiplied by $^{19}/_{40}$ of 1 percent, plus the number of months in the adjusted additional reduction period multiplied by $^{43}/_{240}$ of 1 percent to (ii) the number of months in the reduction period beginning with age 62 multiplied by $^{19}/_{40}$ of 1 percent, plus the number of months in the adjusted reduction period prior to age 62 multiplied by $^{19}/_{40}$ of 1 percent, plus the number of months in the adjusted additional reduction period multiplied by $^{43}/_{240}$ of 1 percent.

such determination being made in accordance with the provisions of paragraph (8).

"(11) When an individual is entitled to more than one monthly benefit under this title and one or more of such benefits are reduced under this subsection, paragraph (10) shall apply separately to each such benefit reduced under this subsection before the application of subsection (k) (pertaining to the method by which monthly benefits are offset when an individual is entitled to more than one kind of benefit) and the application of this paragraph shall operate in conjunction with paragraph (3).".

42 USC 402.

(c)(1) Section 202(q)(7)(C) of such Act is amended by striking out "because" and all that follows and inserting in lieu thereof "because of the occurrence of an event that terminated her or his entitlement to such benefits,".

(2) Section 202(q)(3)(H) of such Act is amended by inserting "for that month or" after "first entitled".

Effective date.
42 USC 402 note.

(d) The amendments made by this section shall be effective with respect to monthly benefits payable for months after December 1977.

LIMITATION ON RETROACTIVE BENEFITS

SEC. 332. (a)(1) The first sentence of section 202(j)(1) of the Social Security Act is amended by striking out "An individual" and inserting in lieu thereof "Subject to the limitations contained in paragraph (4), an individual".

(2) Section 202(j) of such Act is further amended by adding at the end thereof the following new paragraph: 42 USC 402.

"(4)(A) Except as provided in subparagraph (B), no individual shall be entitled to a monthly benefit under subsection (a), (b), (c), (e), or (f) for any month prior to the month in which he or she files an application for benefits under that subsection if the effect of entitlement to such benefit would be to reduce, pursuant to subsection (q), the amount of the monthly benefit to which such individual would otherwise be entitled for the month in which such application is filed.

"(B)(i) If the individual applying for retroactive benefits is applying for such benefits under subsection (a), and there are one or more other persons who would (except for subparagraph (A)) be entitled for any month, on the basis of the wages and self-employment income of such individual and because of such individual's entitlement to such retroactive benefits, to retroactive benefits under subsection (b), (c), or (d) not subject to reduction under subsection (q), then subparagraph (A) shall not apply with respect to such month or any subsequent month.

"(ii) If the individual applying for retroactive benefits is a widow, surviving divorced wife, or widower and is under a disability (as defined in section 223(d)), and such individual would, except for subparagraph (A), be entitled to retroactive benefits as a disabled widow or widower or disabled surviving divorced wife for any month before attaining the age of 60, then subparagraph (A) shall not apply with respect to such month or any subsequent month. 42 USC 423.

"(iii) If the individual applying for retroactive benefits has excess earnings (as defined in section 203(f)) in the year in which he or she files an application for such benefits which could, except for subparagraph (A), be charged to months in such year prior to the month of application, then subparagraph (A) shall not apply to so many of such months immediately preceding the month of application as are required to charge such excess earnings to the maximum extent possible. 42 USC 403.

"(iv) As used in this subparagraph, the term 'retroactive benefits' means benefits to which an individual becomes entitled for a month prior to the month in which application for such benefits is filed.". "Retroactive benefits."

(3) Section 226(h) of such Act is amended by adding at the end thereof the following new paragraph: 42 USC 426.

"(4) For purposes of determining entitlement to hospital insurance benefits under subsection (b) in the case of an individual described in clause (iii) of subsection (b)(2)(A), the entitlement of such individual to widow's or widower's insurance benefits under section 202 (e) or (f) by reason of a disability shall be deemed to be the entitlement to such benefits that would result if such entitlement were determined without regard to the provisions of section 202(j)(4).". 42 USC 402.

(b) The amendments made by subsection (a) shall be effective with respect to monthly insurance benefits under title II of the Social Security Act to which an individual becomes entitled on the basis of an application filed on or after January 1, 1978. Effective date. 42 USC 402 note. 42 USC 401.

DELIVERY OF BENEFIT CHECKS

SEC. 333. (a) Title VII of the Social Security Act is amended by adding at the end thereof the following new section:

"DELIVERY OF BENEFIT CHECKS

42 USC 909.
42 USC 401, 1381.

"SEC. 708. (a) If the day regularly designated for the delivery of benefit checks under title II or title XVI falls on a Saturday, Sunday, or legal public holiday (as defined in section 6103 of title 5, United States Code) in any month, the benefit checks which would otherwise be delivered on such day shall be mailed for delivery on the first day preceding such day which is not a Saturday, Sunday, or legal public holiday (as so defined), without regard to whether the delivery of such checks would as a result have to be made before the end of the month for which such checks are issued.

42 USC 404, 1383.

"(b) If more than the correct amount of payment under title II or XVI is made to any individual as a result of the receipt of a benefit check pursuant to subsection (a) before the end of the month for which such check is issued, no action shall be taken (under section 204 or 1631(b) or otherwise) to recover such payment or the incorrect portion thereof.".

Effective date.
42 USC 909 note.

(b) The amendment made by subsection (a) of this section shall apply with respect to benefit checks the regularly designated day for delivery of which occurs on or after the thirtieth day after the date of the enactment of this Act.

REDUCED BENEFITS FOR SPOUSES RECEIVING GOVERNMENT PENSIONS

42 USC 402.

SEC. 334. (a)(1) Section 202(b)(2) of the Social Security Act is amended by inserting after "subsection (q)" the following: "and paragraph (4) of this subsection".

(2) Section 202(b) of such Act is further amended by adding at the end thereof the following new paragraph:

42 USC 418.
42 USC 410.

"(4)(A) The amount of a wife's insurance benefit for each month as determined after application of the provisions of subsections (q) and (k) shall be reduced (but not below zero) by an amount equal to the amount of any monthly periodic benefit payable to such wife (or divorced wife) for such month which is based upon her earnings while in the service of the Federal Government or any State (or political subdivision thereof, as defined in section 218(b)(2)) if, on the last day she was employed by such entity, such service did not constitute 'employment' as defined in section 210.

"Periodic benefit."

"(B) For purposes of this paragraph, any periodic benefit which otherwise meets the requirements of subparagraph (A), but which is paid on other than a monthly basis, shall be allocated on a basis equivalent to a monthly benefit (as determined by the Secretary) and such equivalent monthly benefit shall constitute a monthly periodic benefit for purposes of subparagraph (A). For purposes of this subparagraph, the term 'periodic benefit' includes a benefit payable in a lump sum if it is a commutation of, or a substitute for, periodic payments.".

42 USC 402.

(b)(1) Section 202(c)(1) of such Act is amended—

(A) by striking out subparagraph (C);

(B) by adding "and" at the end of subparagraph (B); and

(C) by redesignating subparagraph (D) as subparagraph (C).

(2) Section 202(c)(2) of such Act is amended to read as follows:

"(2)(A) The amount of a husband's insurance benefit for each month as determined after application of the provisions of subsections (q) and (k) shall be reduced (but not below zero) by an amount equal to the amount of any monthly periodic benefit payable to such husband for such month which is based upon his earnings while in the service of the Federal Government or any State (or political subdivision thereof, as defined in section 218(b)(2)) if, on the last day he was employed by such entity, such service did not constitute 'employment' as defined in section 210.

42 USC 418.

Post, p. 1549.

"(B) For purposes of this paragraph, any periodic benefit which otherwise meets the requirements of subparagraph (A), but which is paid on other than a monthly basis, shall be allocated on a basis equivalent to a monthly benefit (as determined by the Secretary) and such equivalent monthly benefit shall constitute a monthly periodic benefit for purposes of subparagraph (A). For purposes of this subparagraph, the term 'periodic benefit' includes a benefit payable in a lump sum if it is a commutation of, or a substitute for, periodic payments.".

"Periodic benefit."

(3) Section 202(c)(3) of such Act is amended by inserting after "subsection (q)" the following: "and paragraph (2) of this subsection".

42 USC 402.

(c)(1) Section 202(e)(2)(A) of such Act (as amended by section 204(a) of this Act) is amended by striking out "paragraph (4)" in the first sentence and inserting in lieu thereof "paragraphs (4) and (8)".

(2) Section 202(e) of such Act is further amended by adding at the end thereof the following new paragraph:

"(8)(A) The amount of a widow's insurance benefit for each month as determined (after application of the provisions of subsections (q) and (k), paragraph (2)(B), and paragraph (4)) shall be reduced (but not below zero) by an amount equal to the amount of any monthly periodic benefit payable to such widow (or surviving divorced wife) for such month which is based upon her earnings while in the service of the Federal Government or any State (or any political subdivision thereof, as defined in section 218(b)(2)) if, on the last day she was employed by such entity, such service did not constitute 'employment' as defined in section 210.

"(B) For purposes of this paragraph, any periodic benefit which otherwise meets the requirements of subparagraph (A), but which is paid on other than a monthly basis, shall be allocated on a basis equivalent to a monthly benefit (as determined by the Secretary) and such equivalent monthly benefit shall constitute a monthly periodic benefit for purposes of subparagraph (A). For purposes of this subparagraph, the term 'periodic benefit' includes a benefit payable in a lump sum if it is a commutation of, or a substitute for, periodic payments.".

"Periodic benefit."

(d)(1) Section 202(f)(1) of such Act is amended—

42 USC 402.

(A) by striking out subparagraph (D); and

(B) by redesignating subparagraphs (E), (F), and (G) as subparagraphs (D), (E), and (F), respectively.

(2) Section 202(f)(2) of such Act is amended to read as follows:

"(2)(A) The amount of a widower's insurance benefit for each month (as determined after application of the provisions of subsections (k) and (q), paragraph (3)(B), and paragraph (5)) shall be reduced (but not below zero) by an amount equal to the amount of any monthly periodic benefit payable to such widower for such month which is based upon his earnings while in the service of the Federal Government or any State (or any political subdivision thereof, as defined in section 218(b)(2)) if, on the last day he was employed by such entity, such service did not constitute 'employment' as defined in section 210.

"(B) For purposes of this paragraph, any periodic benefit which otherwise meets the requirements of subparagraph (A), but which is paid on other than a monthly basis, shall be allocated on a basis equivalent to a monthly benefit (as determined by the Secretary) and such

"Periodic benefit."

equivalent monthly benefit shall constitute a monthly periodic benefit for purposes of subparagraph (A). For purposes of this subparagraph, the term 'periodic benefit' includes a benefit payable in a lump sum if it is a commutation of, or a substitute for, periodic payments.".

Ante, p. 1528.

(3) Section 202(f)(3)(A) of such Act (as amended by section 204(c) of this Act) is amended by striking out "paragraph (5)" in the first sentence and inserting in lieu thereof "paragraphs (2) and (5)".

(4)(A) Section 202(f)(7) of such Act is amended by striking out "paragraph (1)(G)" and inserting in lieu thereof "paragraph (1)(F)".

42 USC 426.

(B) Section 226(h)(1)(B) of such Act is amended by striking out "subparagraph (G) of section 202(f)(1)" and inserting in lieu thereof "subparagraph (F) of section 202(f)(1)".

(5) Section 202(p)(1) of such Act is amended by striking out "subparagraph (C) of subsection (c)(1), clause (i) or (ii) of subparagraph (D) of subsection (f)(1), or".

(6) Section 202(s)(3) of such Act is amended by striking out "Subsections" and all that follows down through "so much" and inserting in lieu thereof "So much".

(e)(1) Section 202(g)(2) of such Act is amended by striking out "Such" and inserting in lieu thereof "Except as provided in paragraph (4) of this subsection, such".

(2) Section 202(g) of such Act is further amended by adding at the end thereof the following new paragraph:

"(4)(A) The amount of a mother's insurance benefit for each month to which any individual is entitled under this subsection (as determined after application of subsection (k)) shall be reduced (but not below zero) by an amount equal to the amount of any monthly periodic benefit payable to such individual for such month which is based upon such individual's earnings while in the service of the Federal Government or any State (or political subdivision thereof, as defined in section 218(b)(2)) if, on the last day such individual was employed by such entity, such service did not constitute 'employment' as defined in section 210.

42 USC 418.

Post, p. 1549.

"(B) For purposes of this paragraph, any periodic benefit which otherwise meets the requirements of subparagraph (A), but which is paid on other than a monthly basis, shall be allocated on a basis equivalent to a monthly benefit (as determined by the Secretary) and such equivalent monthly benefit shall constitute a monthly periodic benefit for purposes of subparagraph (A). For purposes of this subparagraph, the term 'periodic benefit' includes a benefit payable in a lump sum if it is a commutation of, or a substitute for, periodic payments.".

"Periodic benefit."

Effective date.
42 USC 402 note.
42 USC 401.

(f) The amendments made by this section shall apply with respect to monthly insurance benefits payable under title II of the Social Security Act for months beginning with the month in which this Act is enacted, on the basis of applications filed in or after the month in which this Act is enacted.

Effective date.
42 USC 402 note.

(g)(1) The amendments made by the preceding provisions of this section shall not apply with respect to any monthly insurance benefit payable, under subsection (b), (c), (e), (f), or (g) (as the case may be) of section 202 of the Social Security Act, to an individual—

(A) to whom there is payable for any month within the 60-month period beginning with the month in which this Act is enacted (or who is eligible in any such month for) a monthly periodic benefit (within the meaning of such provisions) based upon such individual's earnings while in the service of the Federal Government or any State (or political subdivision thereof, as defined in section 218(b)(2) of the Social Security Act); and

42 USC 418.

(B) who at time of application for or initial entitlement to such monthly insurance benefit under such subsection (b), (c), (e), (f), or (g) meets the requirements of that subsection as it was in effect and being administered in January 1977.

Eligibility.

(2) For purposes of paragraph (1)(A), an individual is eligible for a monthly periodic benefit for any month if such benefit would be payable to such individual for that month if such individual were not employed during that month and had made proper application for such benefit.

Separability.

(3) If any provision of this subsection, or the application thereof to any person or circumstance, is held invalid, the remainder of this section shall not be affected thereby, but the application of this subsection to any other persons or circumstances shall also be considered invalid.

SUBSTANTIAL GAINFUL ACTIVITY IN CASE OF BLIND INDIVIDUALS

42 USC 423.

Sec. 335. Section 223(d)(4) of the Social Security Act is amended by inserting after the first sentence the following new sentence: "No individual who is blind shall be regarded as having demonstrated an ability to engage in substantial gainful activity on the basis of earnings that do not exceed the exempt amount under section 203(f)(8) which is applicable to individuals described in subparagraph (D) thereof.".

Ante, p. 1530.

REMARRIAGE OF WIDOWS AND WIDOWERS

Sec. 336. (a)(1) Section 202(e)(2)(A) of the Social Security Act (as amended by sections 204(a) and 334(c)(1) of this Act) is amended by striking out "paragraphs (4) and (8)" and inserting in lieu thereof "paragraph (8)".

Ante, pp. 1527, 1544.

(2) Section 202(e)(3) of such Act is amended by striking out "In the case of a widow or surviving divorced wife who marries" in the matter preceding subparagraph (A) and inserting in lieu thereof "If a widow, before attaining age 60, or a surviving divorced wife, marries".

42 USC 402.

(3) Section 202(e)(4) of such Act is amended to read as follows:

"(4) If a widow, after attaining age 60, marries, such marriage shall, for purposes of paragraph (1), be deemed not to have occurred.".

Ante, pp. 1528, 1546.

(b)(1) Section 202(f)(3)(A) of such Act (as amended by sections 204(c) and 334(d)(3) of this Act) is further amended by striking out "paragraphs (2) and (5)" and inserting in lieu thereof "paragraph (2)".

(2) Section 202(f)(4) of such Act is amended by striking out "In the case of a widower who remarries" in the matter preceding subparagraph (A) and inserting in lieu thereof "If a widower, before attaining age 60, remarries".

(3) Section 202(f)(5) of such Act is amended to read as follows:

"(5) If a widower, after attaining age 60, marries, such marriage shall, for purposes of paragraph (1), be deemed not to have occurred."

Effective date.
42 USC 402 note.

(c)(1) The amendments made by this section shall apply only with respect to monthly benefits payable under title II of the Social Security Act for months after December 1978, and, in the case of individuals who are not entitled to benefits of the type involved for December 1978, only on the basis of applications filed on or after January 1, 1979.

42 USC 401.

Ante, p. 1533;
Post, p. 1535.
26 USC 3121.

Internal Revenue Code of 1954 to have filed a waiver certificate under section 3121(k)(1) of such Code, on or after the first day of the applicable period described in subparagraph (A)(ii) of such section 3121(k)(4) and before July 1, 1977; and

Post, p. 1549.
Post, p. 1555.

Ante, p. 1532.

(2) the service so performed does not constitute employment (as defined in section 210(a) of the Social Security Act and section 3121(b) of such Code) because the waiver certificate which the organization is deemed to have filed is made inapplicable to such service by section 3121(k)(4)(C) of such Code, but would constitute employment (as so defined) in the absence of such section 3121(k)(4)(C),

42 USC 401.

Ante, p. 1510;
Post, p. 1540.

Infra.

Ante, p. 1511.
Post, pp. 1537, 1540.

the remuneration paid for such service shall, upon the request of such individual (filed on or before April 15, 1980, in such manner and form, and with such official, as may be prescribed by regulations made under title II of the Social Security Act) accompanied by full payment of all of the taxes which would have been paid under section 3101 of such Code with respect to such remuneration but for such section 3121(k)(4)(C) (or by satisfactory evidence that appropriate arrangements have been made for the payment of such taxes in installments as provided in section 3121(k)(8) of such Code), be deemed to constitute remuneration for employment as so defined. In any case where remuneration paid by an organization to an individual is deemed under the preceding sentence to constitute remuneration for employment, such organization shall be liable (notwithstanding any other provision of such Code) for payment of the taxes which it would have been required to pay under section 3111 of such Code with respect to such remuneration in the absence of such section 3121(k)(4)(C).

Ante, p. 1532.

(d) Section 3121(k)(8) of the Internal Revenue Code of 1954 (relating to extended period for payment of taxes for retroactive coverage), as amended by subsection (a)(3) of this section, is amended to read as follows:

"(8) EXTENDED PERIOD FOR PAYMENT OF TAXES FOR RETROACTIVE COVERAGE.—Notwithstanding any other provision of this title, in any case where—

"(A) an organization is deemed under paragraph (4) to have filed a valid waiver certificate under paragraph (1), but the applicable period described in paragraph (4)(A)(ii) has terminated and part or all of the taxes imposed by sections 3101 and 3111 with respect to remuneration paid by such organization to its employees after the close of such period remains payable notwithstanding paragraph (4)(C), or

"(B) an organization described in paragraph (5)(A) files a valid waiver certificate under paragraph (1) by March 31, 1978, as described in paragraph (5)(B), or (not having filed such a certificate by that date) is deemed under paragraph (5) to have filed such a certificate on April 1, 1978, or

Remuneration.
26 USC 3121 note.

"(C) an individual files a request under section 3 of Public Law 94-563, or under section 312(c) of the Social Security Amendments of 1977, to have service treated as constituting remuneration for employment (as defined in section 3121(b) and in section 210(a) of the Social Security Act),

the taxes due under sections 3101 and 3111 with respect to services constituting employment by reason of such certificate for any period prior to the first day of the calendar quarter in which the date of such filing or constructive filing occurs, or with respect to service constituting employment by reason of such request, may be paid in installments over an appropriate period of time, as determined under regulations prescribed by the Secretary, rather than in a lump sum.".

26 USC 3121 note.

(e) The first sentence of section 3 of Public Law 94-563 (in the matter following paragraph (3)) is amended—

(1) by inserting "on or before April 15, 1980," after "filed"; and

(2) by inserting "(or by satisfactory evidence that appropriate arrangements have been made for the repayment of such taxes in installments as provided in section 3121(k)(8) of such Code)" after "so refunded or credited". *Ante*, p. 1534.

26 USC 3121.

(f) Section 3121(k)(4)(A)(i) of the Internal Revenue Code of 1954 (relating to constructive filing of certificate where no refund or credit of taxes has been made) is amended by striking out "or any subsequent date" and inserting in lieu thereof "(or, if later, as of the earliest date on which it satisfies clause (ii) of this subparagraph.)".

(g) Section 3121(k)(4)(B) of such Code (relating to constructive filing of certificate where no refund or credit of taxes has been made) is amended—

(1) by striking out the period at the end of clause (ii) and inserting in lieu thereof ", or"; and

(2) by adding after clause (ii) the following new clause:

"(iii) the organization, prior to the end of the period referred to in clause (ii) of such subparagraph (and, in the case of an organization organized on or before October 9, 1969, prior to October 19, 1976), had applied for a ruling or determination letter acknowledging it to be exempt from income tax under section 501(c)(3), and it subsequently received such ruling or determination letter and did not pay any taxes under sections 3101 and 3111 with respect to any employee with respect to any quarter ending after the twelfth month following the date of mailing of such ruling or determination letter and did not pay any such taxes with respect to any quarter beginning after the later of (I) December 31, 1975 or (II) the date on which such ruling or determination letter was issued.".

26 USC 501.

Ante, p. 1510; *Post*, p. 1540.

Ante, p. 1511; *Post*, pp. 1537, 1540.

Effective date.
26 USC 3121 note.

(h) The amendments made by subsections (a), (b), (d), (e), (f), and (g) of this section shall be effective as though they had been included as a part of the amendments made to section 3121(k) of the Internal Revenue Code of 1954 by the first section of Public Law 94-563 (or, in the case of the amendments made by subsection (e), as a part of section 3 of such Public Law).

EXCLUSION FROM COVERAGE OF CERTAIN LIMITED PARTNERSHIP INCOME

SEC. 313. (a) Section 211(a) of the Social Security Act is amended— 42 USC 411.

(1) by striking out "and" at the end of paragraph (9);

(2) by striking out the period at the end of paragraph (10) and inserting in lieu thereof "; and"; and

(3) by inserting after paragraph (10) the following new paragraph:

"(11) There shall be excluded the distributive share of any item of income or loss of a limited partner, as such, other than guaranteed payments described in section 707(c) of the Internal Revenue Code of 1954 to that partner for services actually rendered to or on behalf of the partnership to the extent that those payments are established to be in the nature of remuneration for those services.".

26 USC 707.

Ante, pp. 1545, 1547.
Ante, pp. 1528, 1546.

(2) In the case of an individual who was entitled for the month of December 1978 to monthly insurance benefits under subsection (e) or (f) of section 202 of the Social Security Act to which the provisions of subsection (e)(4) or (f)(5) applied, the Secretary shall, if such benefits would be increased by the amendments made by this section, redetermine the amount of such benefits for months after December 1978 as if such amendments had been in effect for the first month for which the provisions of section 202(e)(4) or 202(f)(5) became applicable.

42 USC 402 note.

(d) Where—

42 USC 402.

(1) two or more persons are entitled to monthly benefits under section 202 of the Social Security Act for December 1978 on the basis of the wages and self-employment income of a deceased individual, and one or more of such persons is so entitled under subsection (e) or (f) of such section 202, and

(2) one or more of such persons is entitled on the basis of such wages and self-employment income to monthly benefits under subsection (e) or (f) of such section 202 (as amended by this section) for January 1979, and

Ante, p. 1524.

(3) the total of benefits to which all persons are entitled under section 202 of such Act on the basis of such wages and self-employment income for January 1979 is reduced by reason of section 203(a) of such Act as amended by this Act (or would, but for the first sentence of section 203(a)(4), be so reduced),

then the amount of the benefit to which each such person referred to in paragraph (1) is entitled for months after December 1978 shall in no case be less after the application of this section and such section 203(a) than the amount it would have been without the application of this section.

DURATION-OF-MARRIAGE REQUIREMENT

42 USC 416.

SEC. 337. (a) Section 216(d) of the Social Security Act is amended by striking out "20 years" in paragraphs (1) and (2) and inserting in lieu thereof in each instance "10 years".

(b) Section 202(b)(1)(G) of such Act is amended by striking out "20 years" and inserting in lieu thereof "10years".

Effective date.
42 USC 402 note.
42 USC 401.

(c) The amendments made by this section shall apply with respect to monthly benefits payable under title II of the Social Security Act for months after December 1978, and, in the case of individuals who are not entitled to benefits of the type involved for December 1978, only on the basis of applications filed on or after January 1, 1979.

PART D—STUDY WITH RESPECT TO GENDER-BASED DISTINCTIONS

STUDY OF PROPOSALS TO ELIMINATE DEPENDENCY AND SEX DISCRIMINATION UNDER THE SOCIAL SECURITY PROGRAM

42 USC 902 note.

SEC. 341. (a) The Secretary of Health, Education, and Welfare, in consultation with the Task Force on Sex Discrimination in the Department of Justice, shall make a detailed study, within the Department of Health, Education, and Welfare and the Social Security Administration, of proposals to eliminate dependency as a factor in the determination of entitlement to spouse's benefits under the program established under title II of the Social Security Act, and of proposals to bring about equal treatment for men and women in any and all respects under such program, taking into account the practical effects (particularly the effect upon women's entitlement to such benefits) of factors such as—

(1) changes in the nature and extent of women's participation in the labor force,

(2) the increasing divorce rate, and

(3) the economic value of women's work in the home.

The study shall include appropriate cost analyses.

(b) The Secretary shall submit to the Congress within six months after the date of the enactment of this Act a full and complete report on the study carried out under subsection (a).

Report to Congress.

PART E—COMBINED SOCIAL SECURITY AND INCOME TAX ANNUAL REPORTING

Subpart 1—Amendments to Title II of the Social Security Act

ANNUAL CREDITING OF QUARTERS OF COVERAGE

SEC. 351. (a)(1) Sections 209(g)(3), 209(j), 210(a)(17)(A), and 210(f)(4)(B) of the Social Security Act are each amended by striking out "quarter" wherever it appears and inserting in lieu thereof "year".

42 USC 409, 410.

(2) Sections 209(g)(3) and 209(j) of such Act are each further amended by striking out "$50" and inserting in lieu thereof "$100".

(3)(A) Section 209 of such Act is amended by striking out "or" at the end of subsection (n), by striking out the period at the end of subsection (o) and inserting in lieu thereof "; or", and by inserting after subsection (o) the following new subsection:

"(p) Remuneration paid by an organization exempt from income tax under section 501 of the Internal Revenue Code of 1954 in any calendar year to an employee for service rendered in the employ of such organization, if the remuneration paid in such year by the organization to the employee for such service is less than $100.".

26 USC 501.

(B) Section 210(a)(10) of such Act is amended by striking out "(10)(A)" and all that follows down through "(B) Service" and inserting in lieu thereof "(10) Service", and by redesignating clauses (i) and (ii) as subparagraphs (A) and (B), respectively.

(b) Section 212 of such Act is amended to read as follows:

42 USC 412.

"CREDITING OF SELF-EMPLOYMENT INCOME TO CALENDAR YEARS

"SEC. 212. (a) For the purposes of determining average monthly wage and quarters of coverage the amount of self-employment income derived during any taxable year which begins before 1978 shall—

"(1) in the case of a taxable year which is a calendar year, be credited equally to each quarter of such calendar year; and

"(2) in the case of any other taxable year, be credited equally to the calendar quarter in which such taxable year ends and to each of the next three or fewer preceding quarters any part of which is in such taxable year.

"(b) For the purposes of determining average indexed monthly earnings, average monthly wage, and quarters of coverage the amount of self-employment income derived during any taxable year which begins after 1977 shall—

"(1) in the case of a taxable year which is a calendar year or which begins with or during a calendar year and ends with or during such year, be credited to such calendar year; and

"(2) in the case of any other taxable year, be allocated proportionately to the two calendar years, portions of which are included within such taxable year, on the basis of the number of months in each such calendar year which are included completely within the taxable year.

For purposes of clause (2), the calendar month in which a taxable year ends shall be treated as included completely within that taxable year.".

"Quarters of coverage."
42 USC 413.

(c) Section 213(a)(2) of such Act is amended to read as follows:

"(2)(A) The term 'quarters of coverage' means—

"(i) for calendar years before 1978, and subject to the provisions of subparagraph (B), a quarter in which an individual has been paid $50 or more in wages (except wages for agricultural labor paid after 1954) or for which he has been credited (as determined under section 212) with $100 or more of self-employment income; and

Ante, p. 1549.

"(ii) for calendar years after 1977, and subject to the provisions of subparagraph (B), each portion of the total of the wages paid and the self-employment income credited (pursuant to section 212) to an individual in a calendar year which equals $250, with such quarter of coverage being assigned to a specific calendar quarter in such calendar year only if necessary in the case of any individual who has attained age 62 or died or is under a disability and the requirements for insured status in subsection (a) or (b) of section 214, the requirements for entitlement to a computation or recomputation of his primary insurance amount, or the requirements of paragraph (3) of section 216(i) would not otherwise be met.

42 USC 414.
42 USC 416.

"(B) Notwithstanding the provisions of subparagraph (A)—

"(i) no quarter after the quarter in which an individual dies shall be a quarter of coverage, and no quarter any part of which is included in a period of disability (other than the initial quarter and the last quarter of such period) shall be a quarter of coverage;

"(ii) if the wages paid to an individual in any calendar year equal to $3,000 in the case of a calendar year before 1951, or $3,600 in the case of a calendar year after 1950 and before 1955, or $4,200 in the case of a calendar year after 1954 and before 1959, or $4,800 in the case of a calendar year after 1958 and before 1966, or $6,600 in the case of a calendar year after 1965 and before 1968, or $7,800 in the case of a calendar year after 1967 and before 1972, or $9,000 in the case of the calendar year 1972, or $10,800 in the case of the calendar year 1973, or $13,200 in the case of the calendar year 1974, or an amount equal to the contribution and benefit base (as determined under section 230) in the case of any calendar year after 1974 and before 1978 with respect to which such contribution and benefit base is effective, each quarter of such year shall (subject to clauses (i) and (v)) be a quarter of coverage;

Ante, p. 1513;
Post, p. 1554.

"(iii) if an individual has self-employment income for a taxable year, and if the sum of such income and the wages paid to him during such year equals $3,600 in the case of a taxable year beginning after 1950 and ending before 1955, or $4,200 in the case of a taxable year ending after 1954 and before 1959, or $4,800 in the case of a taxable year ending after 1958 and before 1966, or $6,600 in the case of a taxable year ending after 1965 and before 1968, or $7,800 in the case of a taxable year ending after 1967 and before 1972, or $9,000 in the case of a taxable year beginning after 1971 and before 1973, or $10,800 in the case of a taxable year beginning after 1972 and before 1974, or $13,200 in the case of a taxable year beginning after 1973 and before 1975, or an amount equal to the contribution and benefit base (as determined under section 230) which is effective for the calendar year in the case of any taxable year beginning in any calendar year after 1974 and before 1978, each quarter any part of which falls in such year shall (subject to clauses (i) and (v)) be a quarter of coverage; *Ante*, p. 1513; *Post*, p. 1554.

"(iv) if an individual is paid wages for agricultural labor in a calendar year after 1954 and before 1978, then, subject to clauses (i) and (v), (I) the last quarter of such year which can be but is not otherwise a quarter of coverage shall be a quarter of coverage if such wages equal or exceed $100 but are less than $200; (II) the last two quarters of such year which can be but are not otherwise quarters of coverage shall be quarters of coverage if such wages equal or exceed $200 but are less than $300; (III) the last three quarters of such year which can be but are not otherwise quarters of coverage shall be quarters of coverage if such wages equal or exceed $300 but are less than $400; and (IV) each quarter of such year which is not otherwise a quarter of coverage shall be a quarter of coverage if such wages are $400 or more;

"(v) no quarter shall be counted as a quarter of coverage prior to the beginning of such quarter;

"(vi) not more than one quarter of coverage may be credited to a calendar quarter; and

"(vii) no more than four quarters of coverage may be credited to any calendar year after 1977.

If in the case of an individual who has attained age 62 or died or is under a disability and who has been paid wages for agricultural labor in a calendar year after 1954 and before 1978, the requirements for insured status in subsection (a) or (b) of section 214, the requirements 42 USC 414. for entitlement to a computation or recomputation of his primary insurance amount, or the requirements of paragraph (3) of section 216(i) are not met after assignment of quarters of coverage to quarters in such year as provided in clause (iv) of the preceding sentence, but would be met if such quarters of coverage were assigned to different quarters in such year, then such quarters of coverage shall instead be assigned, for purposes only of determining compliance with such requirements, to such different quarters. If, in the case of an individual who did not die prior to January 1, 1955, and who attained age 62 (if a woman) or age 65 (if a man) or died before July 1, 1957, the requirements for insured status in section 214(a)(3) are not met because of his having too few quarters of coverage but would be met if his quarters of coverage in the first calendar year in which he had any covered employment had been determined on the basis of the period during which wages were earned rather than on the basis of the period during which wages were paid (any such wages paid that are reallocated on an earned basis shall not be used in determining quarters of coverage for subsequent calendar years), then upon application filed by the individual or his survivors and satisfactory proof of his record of wages earned being furnished by such individual or his survivors, the quarters of coverage in such calendar year may be determined on the basis of the periods during which wages were earned.".

(d) The amendments made by subsection (a) shall apply with **Effective dates.** respect to remuneration paid and services rendered after December 31, **42 USC 409 note.**

1977. The amendments made by subsections (b) and (c) shall be effective January 1, 1978.

ADJUSTMENT IN AMOUNT REQUIRED FOR A QUARTER OF COVERAGE

Ante, p. 1549.

SEC. 352. (a) Section 213(a)(2)(A)(ii) of the Social Security Act, as amended by section 351(c) of this Act, is amended by striking out "$250" and inserting in lieu thereof "the amount required for a quarter of coverage in that calendar year (as determined under subsection (d))".

(b) Section 213 of such Act is further amended by adding at the end thereof the following new subsection:

"Amount Required for a Quarter of Coverage

"(d)(1) The amount of wages and self-employment income which an individual must have in order to be credited with a quarter of coverage in any year under subsection (a)(2)(A)(ii) shall be $250 in the calendar year 1978 and the amount determined under paragraph (2) of this subsection for years after 1978.

Publication in Federal Register.

"(2) The Secretary shall, on or before November 1 of 1978 and of every year thereafter, determine and publish in the Federal Register the amount of wages and self-employment income which an individual must have in order to be credited with a quarter of coverage in the succeeding calendar year. The amount required for a quarter of coverage shall be the larger of—

"(A) the amount in effect in the calendar year in which the determination under this subsection is made, or

"(B) the product of the amount prescribed in paragraph (1) which is required for a quarter of coverage in 1978 and the ratio of the average of the total wages (as defined in regulations of the Secretary and computed without regard to the limitations specified in section 209(a)) reported to the Secretary of the Treasury or his delegate for the calendar year before the year in which the determination under this paragraph is made to the average of the total wages (as so defined and computed) reported to the Secretary of the Treasury or his delegate for 1976 (as published in the Federal Register in accordance with section 215(a)(1)(D)),

42 USC 409.

Ante, p. 1514.

with such product, if not a multiple of $10, being rounded to the next higher multiple of $10 where such amount is a multiple of $5 but not of $10 and to the nearest multiple of $10 in any other case.".

Effective date. 42 USC 413 note.

(c) The amendments made by this section shall be effective January 1, 1978.

TECHNICAL AND CONFORMING AMENDMENTS

42 USC 403.

SEC. 353. (a)(1) Section 203(f)(8)(B)(i) of the Social Security Act is amended by striking out "was" wherever it appears and inserting in lieu thereof "is".

(2) Section 203(f)(8)(B)(ii) of such Act is amended to read as follows:

"(ii) the product of the exempt amount described in clause (i) and the ratio of (I) the average of the total wages (as defined in regulations of the Secretary and computed without regard to the limitations specified in section 209(a)) reported to the Secretary of the Treasury or his delegate for the calendar year before the calendar year in which the determination under subparagraph (A) is made to (II) the average of the total wages (as so defined and computed) reported to the Secretary of the Treasury or his delegate for the calendar year before the most recent calendar year in which an increase in the exempt amount was enacted or a determination resulting in such an increase was made under subparagraph (A), with such product, if not a multiple of $10, being rounded to the next higher multiple of $10 where such product is a multiple of $5 but not of $10 and to the nearest multiple of $10 in any other case.".

(b)(1) The first sentence of section 218(c)(8) of such Act is amended by striking out "quarter" wherever it appears and inserting in lieu thereof "year", and by striking out "$50" and inserting in lieu thereof "$100". 42 USC 418.

(2) Section 218(g)(1) of such Act is amended by striking out "quarter" and inserting in lieu thereof "year".

(3) Section 218(q)(4)(B) of such Act is amended by striking out "any calendar quarters" and inserting in lieu thereof "a calendar year" and by striking out "such calendar quarters" and inserting in lieu thereof "such calendar year".

(4) Section 218(q)(6)(B) of such Act is amended by striking out "calendar quarters designated by the State in such wage reports as the" and inserting in lieu thereof "period or periods designated by the State in such wage reports as the period or".

(5) Section 218(r)(1) of such Act is amended—

(A) by striking out "quarter" in the matter before clause (A) and inserting in lieu thereof "year",

(B) by striking out "in which occurred the calendar quarter" in clause (A), and

(C) by striking out "quarter" in clause (B) and inserting in lieu thereof "year".

(c)(1) Effective with respect to estimates for calendar years beginning after December 31, 1977, section 224(a) of such Act is amended by striking out the last sentence. *Ante*, p. 1529.

(2) Section 224(f)(2) of such Act is amended to read as follows:

"(2) In making the redetermination required by paragraph (1), the individual's average current earnings (as defined in subsection (a)) shall be deemed to be the product of—

"(A) his average current earnings as initially determined under subsection (a);

"(B) the ratio of (i) the average of the total wages (as defined in regulations of the Secretary and computed without regard to the limitations specified in section 209(a)) reported to the Secretary of the Treasury or his delegate for the calendar year before the year in which such redetermination is made to (ii) the average of the total wages (as so defined and computed) reported to the Secretary of the Treasury or his delegate for calendar year 1977 or, if later, the calendar year before the year in which the reduction was first computed (but not counting any reduction made in benefits for a previous period of disability); and 42 USC 409.

"(C) in any case in which the reduction was first computed before 1978, the ratio of (i) the average of the taxable wages reported to the Secretary for the first calendar quarter of 1977 to (ii) the average of the taxable wages reported to the Secretary for the first calendar quarter of the calendar year before the year in which the reduction was first computed (but not counting any reduction made in benefits for a previous period of disability).

Any amount determined under this paragraph which is not a multiple of $1 shall be reduced to the next lower multiple of $1.".

42 USC 429.

(d) Section 229(a) of such Act is amended—

(1) by striking out "shall be deemed to have been paid, in each calendar quarter occurring after 1956 in which he" and inserting in lieu thereof ", if he", and

(2) by striking out "wages (in addition to the wages actually paid to him for such service) of $300." at the end thereof and inserting in lieu thereof the following: "shall be deemed to have been paid—

"(1) in each calendar quarter occurring after 1956 and before 1978 in which he was paid such wages, additional wages of $300, and

"(2) in each calendar year occurring after 1977 in which he was paid such wages, additional wages of $100 for each $300 of such wages, up to a maximum of $1,200 of additional wages for any calendar year.".

42 USC 430.

(e)(1) Section 230(b) of such Act is amended by striking out the last sentence.

(2) Section 230(b)(1) of such Act is amended to read as follows:

"(1) the contribution and benefit base which is in effect with respect to remuneration paid in (and taxable years beginning in) the calendar year in which the determination under subsection (a) is made, and".

(3) Section 230(b)(2) of such Act is amended to read as follows:

42 USC 409.

"(2) the ratio of (A) the average of the total wages (as defined in regulations of the Secretary and computed without regard to the limitations specified in section 209(a)) reported to the Secretary of the Treasury or his delegate for the calendar year before the calendar year in which the determination under subsection (a) is made to (B) the average of the total wages (as so defined and computed) reported to the Secretary of the Treasury or his delegate for the calendar year before the most recent calendar year in which an increase in the contribution and benefit base was enacted or a determination resulting in such an increase was made under subsection (a),".

42 USC 402.

(f)(1) Effective with respect to convictions after December 31, 1977, section 202(u)(1)(C) of such Act is amended by striking out "quarter" wherever it appears and inserting in lieu thereof "year".

42 USC 405.

(2)(A) Section 205(c)(1) of such Act is amended by striking out "(as defined in section 211(e))".

"Period."

(B) Section 205(c)(1) of such Act is further amended by adding at the end thereof the following new subparagraph:

"(D) The term 'period' when used with respect to self-employment income means a taxable year and when used with respect to wages means—

26 USC 6011.
42 USC 418.

"(i) a quarter if wages were reported or should have been reported on a quarterly basis on tax returns filed with the Secretary of the Treasury or his delegate under section 6011 of the Internal Revenue Code of 1954 or regulations thereunder (or on reports filed by a State under section 218(e) or regulations thereunder),

"(ii) a year if wages were reported or should have been reported on a yearly basis on such tax returns or reports, or

"(iii) the half year beginning January 1 or July 1 in the case of wages which were reported or should have been reported for calendar year 1937.".

(C) Section 205(o) of such Act is amended by inserting "before 1978" after "calendar year". 42 USC 405.

(g) The amendments made by subsection (b) of this section shall apply with respect to remuneration paid after December 31, 1977, except that the amendment made by subsection (b)(2) shall apply with respect to notices submitted by the States to the Secretary after the date of the enactment of this Act. The amendments made by subsections (d) and (f)(2) shall be effective January 1, 1978. Except as otherwise specifically provided, the remaining amendments made by this section shall be effective January 1, 1979. Effective dates. 42 USC 418 note.

Subpart 2—Amendments to the Internal Revenue Code of 1954

DEDUCTION OF TAX FROM WAGES

SEC. 355. (a) Section 3102(a) of the Internal Revenue Code of 1954 is amended by striking out "or (C) or (10)", and by inserting after "is less than $50;" the following: "and an employer who in any calendar year pays to an employee cash remuneration to which paragraph (7)(C) or (10) of section 3121(a) is applicable may deduct an amount equivalent to such tax from any such payment of remuneration, even though at the time of payment the total amount of such remuneration paid to the employee by the employer in the calendar year is less than $100;". 26 USC 3102. *Infra.*

(b)(1) Paragraphs (1) and (2) of section 3102(c) of such Code are each amended by striking out "quarter" wherever it appears and by inserting in lieu thereof "year".

(2) Paragraph (3) of section 3102(c) of such Code is amended—

(A) by striking out "quarter of the" in subparagraph (A); and

(B) by striking out "quarter" wherever it appears in subparagraphs (B) and (C) and inserting in lieu thereof "year".

(c) The amendments made by this section shall apply with respect to remuneration paid and to tips received after December 31, 1977. Effective date. 26 USC 3102 note.

TECHNICAL AND CONFORMING AMENDMENTS

SEC. 356. (a) Sections 3121(a)(7)(C) and 3121(a)(10) of the Internal Revenue Code of 1954 are each amended by striking out "quarter" wherever it appears and inserting in lieu thereof "year", and by striking out "$50" and inserting in lieu thereof "$100". 26 USC 3121.

(b) Section 3121(a) of such Code is amended by striking out "or" at the end of paragraph (14), by striking out the period at the end of paragraph (15) and inserting in lieu thereof "; or", and by adding after paragraph (15) the following new paragraph:

"(16) remuneration paid by an organization exempt from income tax under section 501(a) (other than an organization described in section 401(a)) or under section 521 in any calendar year to an employee for service rendered in the employ of such organization, if the remuneration paid in such year by the organization to the employee for such service is less than $100.". 26 USC 501. 26 USC 401, 521.

(c) Section 3121(b)(10) of such Code is amended by striking out "(10)(A)" and all that follows down through "(B) service" and inserting in lieu thereof "(10) service", and redesignating clauses (i) and (ii) as subparagraphs (A) and (B), respectively.

(d) Sections 3121(b)(17)(A) and 3121(g)(4)(B) of such Code are each amended by striking out "quarter" and inserting in lieu thereof "year".

Effective date. 26 USC 3121 note.

(e) The amendments made by this section shall apply with respect to remuneration paid and services rendered after December 31, 1977.

Subpart 3—Conforming Amendment to the Railroad Retirement Act of 1974

COMPUTATION OF EMPLOYEE ANNUITIES

45 USC 231b.

SEC. 358. (a) The last sentence of section 3(f)(1) of the Railroad Retirement Act of 1974 is amended—

(1) by inserting "paid before 1978" after "in the case of wages", and

(2) by inserting "and in the case of wages paid after 1977" before the period at the end thereof.

Effective date. 45 USC 231b note.

(b) The amendments made by this section shall be effective January 1, 1978.

PART F—NATIONAL COMMISSION ON SOCIAL SECURITY

ESTABLISHMENT OF COMMISSION

42 USC 907a.

SEC. 361. (a)(1) There is hereby established a commission to be known as the National Commission on Social Security (hereinafter referred to as the "Commission").

Membership.

(2)(A) The Commission shall consist of—

(i) five members to be appointed by the President, by and with the advice and consent of the Senate, one of whom shall, at the time of appointment, be designated as Chairman of the Commission;

(ii) two members to be appointed by the Speaker of the House of Representatives; and

(iii) two members to be appointed by the President pro tempore of the Senate.

Appointment.

(B) At no time shall more than three of the members appointed by the President, one of the members appointed by the Speaker of the House of Representatives, or one of the members appointed by the President pro tempore of the Senate be members of the same political party.

Membership qualifications.

(C) The membership of the Commission shall consist of individuals who are of recognized standing and distinction and who possess the demonstrated capacity to discharge the duties imposed on the Commission, and shall include representatives of the private insurance industry and of recipients and potential recipients of benefits under the programs involved as well as individuals whose capacity is based on a special knowledge or expertise in those programs. No individual who is otherwise an officer or full-time employee of the United States shall serve as a member of the Commission.

Chairman.

(D) The Chairman of the Commission shall designate a member of the Commission to act as Vice Chairman of the Commission.

Quorum.

(E) A majority of the members of the Commission shall constitute a quorum, but a lesser number may conduct hearings.

Term.

(F) Members of the Commission shall be appointed for a term of two years.

Vacancy.

(G) A vacancy in the Commission shall not affect its powers, but shall be filled in the same manner as that herein provided for the appointment of the member first appointed to the vacant position.

(3) Members of the Commission shall receive $138 per diem while engaged in the actual performance of the duties vested in the Commission, plus reimbursement for travel, subsistence, and other necessary expenses incurred in the performance of such duties.

Compensation.

(4) The Commission shall meet at the call of the Chairman, or at the call of a majority of the members of the Commission; but meetings of the Commission shall be held not less frequently than once in each calendar month which begins after a majority of the authorized membership of the Commission has first been appointed.

Meetings.

(b) (1) It shall be the duty and function of the Commission to conduct a continuing study, investigation, and review of—

(A) the Federal old-age, survivors, and disability insurance program established by title II of the Social Security Act; and

(B) the health insurance programs established by title XVIII of such Act.

Study, investigation and review of programs.
42 USC 401.
42 USC 1395.

(2) Such study, investigation, and review of such programs shall include (but not be limited to)—

Contents.

(A) the fiscal status of the trust funds established for the financing of such programs and the adequacy of such trust funds to meet the immediate and long-range financing needs of such programs;

(B) the scope of coverage, the adequacy of benefits including the measurement of an adequate retirement income, and the conditions of qualification for benefits provided by such programs including the application of the retirement income test to unearned as well as earned income;

(C) the impact of such programs on, and their relation to, public assistance programs, nongovernmental retirement and annuity programs, medical service delivery systems, and national employment practices;

(D) any inequities (whether attributable to provisions of law relating to the establishment and operation of such programs, to rules and regulations promulgated in connection with the administration of such programs, or to administrative practices and procedures employed in the carrying out of such programs) which affect substantial numbers of individuals who are insured or otherwise eligible for benefits under such programs, including inequities and inequalities arising out of marital status, sex, or similar classifications or categories;

(E) possible alternatives to the current Federal programs or particular aspects thereof, including but not limited to (i) a phasing out of the payroll tax with the financing of such programs being accomplished in some other manner (including general revenue funding and the retirement bond), (ii) the establishment of a system providing for mandatory participation in any or all of the Federal programs, (iii) the integration of such current Federal programs with private retirement programs, and (iv) the establishment of a system permitting covered individuals a choice of public or private programs or both;

(F) the need to develop a special Consumer Price Index for the elderly, including the financial impact that such an index would have on the costs of the programs established under the Social Security Act; and

42 USC 1305.

(G) methods for effectively implementing the recommendations of the Commission.

(3) In order to provide an effective opportunity for the general public to participate fully in the study, investigation, and review under

this section, the Commission, in conducting such study, investigation, and review, shall hold public hearings in as many different geographical areas of the country as possible. The residents of each area where such a hearing is to be held shall be given reasonable advance notice of the hearing and an adequate opportunity to appear and express their views on the matters under consideration.

Report to President and Congress.

(c) (1) No later than four months after the date on which a majority of the authorized membership of the Commission is initially appointed, the Commission shall submit to the President and the Congress a special report describing the Commission's plans for conducting the study, investigation, and review under subsection (b), with particular reference to the scope of such study, investigation, and review and the methods proposed to be used in conducting it.

Reports to President and Congress; recommendations.

(2) At or before the close of each of the first two years after the date on which a majority of the authorized membership of the Commission is initially appointed, the Commission shall submit to the President and the Congress an annual report on the study, investigation, and review under subsection (b), together with its recommendations with respect to the programs involved. The second such report shall constitute the final report of the Commission on such study, investigation, and review, and shall include its final recommendations; and upon the submission of such final report the Commission shall cease to exist.

Executive Director, appointment and compensation.
5 USC 5316.

(d) (1) The Commission shall appoint an Executive Director of the Commission who shall be compensated at a rate fixed by the Commission, but which shall not exceed the rate established for level V of the Executive Schedule by title 5, United States Code.

(2) In addition to the Executive Director, the Commission shall have the power to appoint and fix the compensation of such personnel as it deems advisable, in accordance with the provisions of title 5, United States Code, governing appointments to the competitive service, and the provisions of chapter 51 and subchapter III of chapter 53 of such title, relating to classification and General Schedule pay rates.

5 USC 5101 *et seq.*, 5331.
Hearings.

(e) In carrying out its duties under this section, the Commission, or any duly authorized committee thereof, is authorized to hold such hearings, sit and act at such times and places, and take such testimony, with respect to matters with respect to which it has a responsibility under this section, as the Commission or such committee may deem advisable. The Chairman of the Commission or any member authorized by him may administer oaths or affirmations to witnesses appearing before the Commission or before any committee thereof.

(f) The Commission may secure directly from any department or agency of the United States such data and information as may be necessary to enable it to carry out its duties under this section. Upon request of the Chairman of the Commission, any such department or agency shall furnish any such data or information to the Commission.

Support services.

(g) The General Services Administration shall provide to the Commission, on a reimbursable basis such administrative support services as the Commission may request.

Appropriation authorization.

(h) There are hereby authorized to be appropriated such sums as may be necessary to carry out this section.

Notice of meetings.
42 USC 1395dd.

(i) It shall be the duty of the Health Insurance Benefits Advisory Council (established by section 1867 of the Social Security Act) to provide timely notice to the Commission of any meeting, and the Chairman of the Commission (or his delegate) shall be entitled to attend any such meeting.

PART G—MISCELLANEOUS PROVISIONS

APPOINTMENT OF HEARING EXAMINERS

42 USC 1383 note.
42 USC 1383.
42 USC 1383 note.

SEC. 371. The persons who were appointed to serve as hearing examiners under section 1631(d)(2) of the Social Security Act (as in effect prior to January 2, 1976), and who by section 3 of Public Law 94-202 were deemed to be appointed under section 3105 of title 5, United States Code (with such appointments terminating no later than at the close of the period ending December 31, 1978), shall be deemed appointed to career-absolute positions as hearing examiners under and in accordance with section 3105 of title 5, United States Code, with the same authority and tenure (without regard to the expiration of such period) as hearing examiners appointed directly under such section 3105, and shall receive compensation at the same rate as hearing examiners appointed by the Secretary of Health, Education, and Welfare directly under such section 3105. All of the provisions of title 5, United States Code, and the regulations promulgated pursuant thereto, which are applicable to hearing examiners appointed under such section 3105, shall apply to the persons described in the preceding sentence. 5 USC 101 *et seq.*

REPORT OF ADVISORY COUNCIL ON SOCIAL SECURITY

42 USC 907 note.
42 USC 907.

SEC. 372. Notwithstanding the provisions of section 706(d) of the Social Security Act, the report of the Advisory Council on Social Security which is due not later than January 1, 1979, may be filed at any date prior to October 1, 1979.

TITLE IV—PROVISIONS RELATING TO CERTAIN STATE WELFARE AND SERVICE PROGRAMS RECEIVING FEDERAL FINANCIAL ASSISTANCE

FISCAL RELIEF FOR STATES AND POLITICAL SUBDIVISIONS WITH RESPECT TO COSTS OF WELFARE PROGRAMS

SEC. 401. Section 403 of the Social Security Act is amended— 42 USC 603.

(1) in subsection (a), by adding at the end thereof the following new paragraph:

"In the case of calendar quarters beginning after September 30, 1977, and prior to April 1, 1978, the amount to be paid to each State (as determined under the preceding provisions of this subsection or section 1118, as the case may be) shall be increased in accordance with the provisions of subsection (i) of this section."; and 42 USC 1318.

(2) by adding at the end thereof the following new subsection:

"(i)(1) In the case of any calendar quarter which begins after September 30, 1977, and prior to April 1, 1978, the amount payable (as determined under subsection (a) or section 1118, as the case may be) to each State which has a State plan approved under this part shall (subject to the succeeding paragraphs of this subsection) be increased by an amount equal to the sum of the following:

"(A) an amount which bears the same ratio to $46,750,000 as the amount expended as aid to families with dependent children under the State plan of such State during the month of December 1976 bears to the amount expended as aid to families with dependent children under the State plans of all States during such month, and

"(B)(i) in the case of Puerto Rico, Guam, and the Virgin Islands, an amount equal to the amount determined under subparagraph (A) with respect to such State, or

"(ii) in the case of any other State, an amount which bears the same ratio to $46,750,000, minus the amounts determined under clause (i) of this subparagraph, as the amount allocated to such State under section 106 of the State and Local Fiscal Assistance Act of 1972, for the most recent entitlement period for which allocations have been made under such section prior to the date of the enactment of this subsection, bears to the total of the amounts allocated to all States under such section 106 for such period. 31 USC 1225.

"(2) As a condition of any State receiving an increase, by reason of the application of the foregoing provisions of this subsection, in the amount determined for such State pursuant to subsection (a) or under section 1118 (as the case may be), such State must agree to pay to any political subdivision thereof which participates in the cost of the State's plan approved under this part, during any calendar quarter with respect to which such increase applies, so much of such increase as does not exceed 100 per centum of such political subdivision's financial contribution to the State's plan for such quarter. 42 USC 1318.

"(3) Notwithstanding any other provision of this part, the amount payable to any State by reason of the preceding provisions of this subsection for calendar quarters prior to April 1, 1978, shall be made in a single installment, which shall be payable as shortly after October 1, 1977, as is administratively feasible.".

INCENTIVE ADJUSTMENTS FOR QUALITY CONTROL IN FEDERAL FINANCIAL PARTICIPATION IN AID TO FAMILIES WITH DEPENDENT CHILDREN PROGRAMS

Ante, p. 1560.

SEC. 402. (a) Section 403 of the Social Security Act is amended by adding after subsection (i) (as added by section 401 of this Act) the following new subsection:

"(j) If the dollar error rate of aid furnished by a State under its State plan approved under this part with respect to any six-month period, as based on samples and evaluations thereof, is—

"(1) at least 4 per centum, the amount of the Federal financial participation in the expenditures made by the State in carrying out such plan during such period shall be determined without regard to the provisions of this subsection; or

"(2) less than 4 per centum, the amount of the Federal financial participation in the expenditures made by the State in carrying out such plan during such period shall be the amount determined without regard to this subsection, plus, of the amount by which such expenditures are less than they would have been if the erroneous excess payments of aid had been at a rate of 4 per centum—

"(A) 10 per centum of the Federal share of such amount, in case such rate is not less than 3.5 per centum,

"(B) 20 per centum of the Federal share of such amount, in case such rate is at least 3.0 per centum but less than 3.5 per centum,

"(C) 30 per centum of the Federal share of such amount, in case such rate is at least 2.5 per centum but less than 3.0 per centum,

"(D) 40 per centum of the Federal share of such amount, in case such rate is at least 2.0 per centum but less than 2.5 per centum, "(E) 50 per centum of the Federal share of such amount, in case such rate is less than 2.0 per centum.

For purposes of this subsection (i) the term 'dollar error rate of aid' means the total of the dollar error rates of aid for (I) payments to ineligible families receiving assistance; (II) overpayments to eligible families receiving assistance; (III) underpayments to eligible families receiving assistance; and (IV) nonpayments to eligible families not receiving assistance due to erroneous terminations or denials, and (ii) the term 'erroneous excess payments,' means the total of (I) erroneous payments to ineligible families receiving assistance, and (II) overpayments to eligible families receiving assistance.". "Dollar error rate of aid."

(b) Payments may be made under the amendment made by subsection (a) only in the case of periods commencing on or after January 1, 1978. Effective date. 42 USC 603 note.

ACCESS TO WAGE INFORMATION

SEC. 403. (a) Part A of title IV of the Social Security Act is amended by adding after section 410 the following new section:

"ACCESS TO WAGE INFORMATION

42 USC 611.

"SEC. 411. (a) Notwithstanding any other provision of law, the Secretary shall make available to States and political subdivisions thereof wage information contained in the records of the Social Security Administration which is necessary (as determined by the Secretary in regulations) for purposes of determining an individual's eligibility for aid or services, or the amount of such aid or services, under a State plan for aid and services to needy families with children approved under this part, and which is specifically requested by such State or political subdivision for such purposes.

"(b) The Secretary shall establish such safeguards as are necessary (as determined by the Secretary under regulations) to insure that information made available under the provisions of this section is used only for the purposes authorized by this section.".

(b) Section 3304(a) of the Federal Unemployment Tax Act is amended by redesignating paragraph (16) as paragraph (17) and by inserting after paragraph (15) the following new paragraph: 26 USC 3304.

"(16)(A) wage information contained in the records of the agency administering the State law which is necessary (as determined by the Secretary of Health, Education, and Welfare in regulations) for purposes of determining an individual's eligibility for aid or services, or the amount of such aid or services, under a State plan for aid and services to needy families with children approved under part A of title IV of the Social Security Act, shall be made available to a State or political subdivision thereof when such information is specifically requested by such State or political subdivision for such purposes, and 42 USC 601.

"(B) such safeguards are established as are necessary (as determined by the Secretary of Health, Education, and Welfare in regulations) to insure that such information is used only for the purposes authorized under subparagraph (A);".

(c) Section 402(a) of the Social Security Act is amended— 42 USC 602.

(1) by striking out the word "and" at the end of paragraph (27);

(2) by striking out the period at the end of paragraph (28) and inserting in lieu thereof a semicolon and the word "and"; and

"(4) Any amount payable to a State under section 403(a) on behalf of an individual participating in a project under this section shall not be increased by reason of the participation of such individual in any demonstration project conducted under this subsection over the amount which would be payable if such individual were receiving aid to families with dependent children and not participating in such project.

"(5) Participation in a project established under this section shall not be considered to constitute employment for purposes of any finding with respect to 'unemployment' as that term is used in section 407. 42 USC 607.

Termination.

"(6) Any demonstration project established and conducted pursuant to the provisions of this subsection shall be conducted for not longer than two years. All demonstration projects established and conducted pursuant to the provisions of this subsection shall be terminated not later than September 30, 1980.".

REIMBURSEMENT FOR ERRONEOUS STATE SUPPLEMENTARY PAYMENT

42 USC 1383 note.

SEC. 405. (a) Notwithstanding any other provision of law, the Secretary of Health, Education, and Welfare is authorized and directed to pay to each State an amount equal to the amount expended by such State for erroneous supplementary payments to aged, blind, or disabled individuals whenever, and to the extent to which, the Secretary through an audit by the Department of Health, Education, and Welfare which has been reviewed and concurred in by the Inspector General of such department determines that—

(1) such amount was paid by such State as a supplementary payment during the calendar year 1974 pursuant to an agreement between the State and the Secretary required by section 212 of the Act entitled "An Act to extend the Renegotiation Act of 1951 for one year, and for other purposes", approved July 9, 1973, or such amount was paid by such State as an optional State supplementation, as defined in section 1616 of the Social Security Act, during the calendar year 1974, 87 Stat. 155. 42 USC 1382e.

(2) the erroneous payments were the result of good faith reliance by such State upon erroneous or incomplete information supplied by the Department of Health, Education, and Welfare, through the State data exchange, or good faith reliance upon incorrect supplemental security income benefit payments made by such department, and

(3) recovery of the erroneous payments by such State would be impossible or unreasonable.

Appropriation authorization.

(b) There are authorized to be appropriated such sums as are necessary to carry out the provisions of this section.

TITLE V—MISCELLANEOUS

COVERAGE UNDER MEDICARE OF CERTAIN POWER-OPERATED WHEELCHAIRS

42 USC 1395x.

SEC. 501. (a) Section 1861(s)(6) of the Social Security Act is amended by inserting after "wheelchairs" the following: "(which may include a power-operated vehicle that may be appropriately used as a wheelchair, but only where the use of such a vehicle is determined to be necessary on the basis of the individual's medical and physical condition and the vehicle meets such safety requirements as the Secretary may prescribe)".

(b) Section 1842(b)(3) of such Act is amended by inserting after the fourth sentence thereof the following new sentence: "With respect to power-operated wheelchairs for which payment may be made in accordance with section 1861(s)(6), charges determined to be reasonable may not exceed the lowest charge at which power-operated wheelchairs are available in the locality." 42 USC 1395u. *Ante*, p. 1564.

(c) The amendments made by this section shall be effective in the case of items and services furnished after the date of the enactment of this Act. Effective date. 42 USC 1395x note.

FEDERAL ELECTION CAMPAIGN ACT AMENDMENTS

SEC. 502. (a) Section 328 of the Federal Election Campaign Act of 1971 (2 U.S.C. 441i) is amended—

(1) by inserting "(a)" immediately after "SEC. 328.", and

(2) by adding at the end thereof the following new subsections:

"(b) If an honorarium payable to a person is paid instead at his request to a charitable organization selected by payor from a list of 5 or more charitable organizations provided by that person, that person shall not be treated, for purposes of subsection (a), as accepting that honorarium. For purposes of this subsection, the term 'charitable organization' means an organization described in section 170(c) of the Internal Revenue Code of 1954. 26 USC 170.

"(c) For purposes of determining the aggregate amount of honorariums received by a person during any calendar year, amounts returned to the person paying an honorarium before the close of the calendar year in which it was received shall be disregarded.

"(d) For purposes of paragraph (2) of subsection (a), an honorarium shall be treated as accepted only in the year in which that honorarium is received.".

(b) The amendments made by subsection (a) shall apply with respect to any honorarium received after December 31, 1976. Effective date. 2 USC 441i note.

Approved December 20, 1977.

LEGISLATIVE HISTORY:

HOUSE REPORTS: No. 95-702, pt. I (Comm. on Ways and Means), No. 95-702, pt. II (Comm. on Post Office and Civil Service) and No. 95-837 (Comm. of Conference).
SENATE REPORT No. 95-572 accompanying H.R. 5322 (Comm. on Finance).
CONGRESSIONAL RECORD, Vol. 123 (1977):
Oct. 26, 27, considered and passed House.
Nov. 1-4, considered and passed Senate, amended.
Dec. 15, Senate and House agreed to conference report.
WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS, Vol. 13, No. 52:
Dec. 20, Presidential statement.

95th Congress, 1st Session - - - - - - House Report No. 702, Part 1

SOCIAL SECURITY FINANCING AMENDMENTS OF 1977

REPORT

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

TOGETHER WITH

INDIVIDUAL VIEWS, DISSENTING VIEWS, MINORITY VIEWS, AND ADDITIONAL MINORITY VIEWS

TO ACCOMPANY

H.R. 9346

(Including cost estimate of the Congressional Budget Office)

October 12, 1977.—Ordered to be printed

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95TH CONGRESS } HOUSE OF REPRESENTATIVES { REPT. 95-702
1st Session } { Part 1

SOCIAL SECURITY FINANCING AMENDMENTS OF 1977

OCTOBER 12, 1977.—Ordered to be printed

Mr. ULLMAN, from the Committee on Ways and Means,
submitted the following

REPORT

together with

INDIVIDUAL VIEWS, DISSENTING VIEWS, MINORITY VIEWS, AND ADDITIONAL MINORITY VIEWS

[To accompany H.R. 9346]

[Including cost estimate of the Congressional Budget Office]

The Committee on Ways and Means, to whom was referred the bill (H.R. 9346) to amend the Social Security Act and the Internal Revenue Code of 1954 to strengthen the financing of the social security system, to reduce the effect of wage and price fluctuation on the system's benefit structure, to provide coverage under the system for officers and employees of the United States, of the State and local governments, and of nonprofit organizations, to increase the earnings limitation, to eliminate certain gender-based distinctions and provide for a study of proposals to eliminate dependency and sex discrimination from the social security program, and for other purposes, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

The amendment strikes out all after the enacting clause of the bill and inserts a new text which appears in italic type in the reported bill.

I. PRINCIPAL PURPOSES AND SCOPE OF THE BILL

Social security today is of major importance to just about every American family. Practically every American is either a beneficiary, a contributor building protection, or the dependent of a contributor. Today 93 percent of the people 65 and older are eligible for social security benefits. Ninety-five out of 100 young children and their mothers are protected by the life insurance features of social security, called survivors' insurance. Four out of five people in the age group 21 through 64 have protection under social security against loss of income due to severe disability. More than 33 million people, one out of seven Americans, receive a social security benefit each month. About 107 million people will pay into the program this year.

Annual trust fund deficits beginning in 1975 have resulted in an erosion of public confidence in the social security system and the Federal Government's commitment to assure sound financing of social security. In order to restore public confidence and, more importantly, to assure that funds will be available to pay benefits as they fall due, your committee's bill would restore the financial soundness of the old-age, survivors, and disability insurance (OASDI) system by eliminating the actuarial deficit in the system through the first decade of the next century and reduce the deficit for the next seventy-five years from 8.2 percent of taxable payroll to 1.69 percent. More specifically, the bill would revise and stabilize the social security benefit structure, extend mandatory social security coverage, eliminate gender-based distinctions in the OASDI system and improve protection for a worker's spouse or surviving spouse, and increase the amount of earnings on older beneficiary age 65 or over may have and still receive some or all of his benefits.

The action taken to date by your committee is intended to deal with only the most pressing problems facing the social security system. The Subcommittee on Social Security has announced its intention to undertake phase II of consideration of social security legislation early in 1978 when it will take up possible amendments to the disability insurance program. Although your committee's bill does reallocate very substantial revenues into the Disability Insurance Trust Fund and will provide adequate financing into the next century, attention must still be focussed on why the costs of the program have risen so rapidly to a level far greater than anticipated. The possibility of not only reducing the cost of the program but also making it more susceptible to administrative control must be thoroughly explored. Following action on the disability insurance program, the Subcommittee will then turn its efforts to other aspects of the cash-benefits program which could be modified in a way that would not impair the long-range financial condition of the program.

A. FINANCING

The bill would restore the financial soundness of the system by providing—

A. Additional allocations of contribution income to the DI trust fund beginning in 1978 and a shift of a small portion of the existing scheduled tax increases from the hospital insurance (HI) part of the program to the cash benefit program (OASDI);

B. Phased increases in the contribution and benefit base in 1978, 1979, 1980, and 1981 to achieve a base level under which about 90 percent of total payroll in covered employment would be taxable (as compared with about 85 percent under present law); and

C. A schedule of social security tax rate increases in 1981, 1985, and 1990 sufficient to meet the cost of the program as amended by your committee's bill.

B. BENEFIT STRUCTURE (DECOUPLING)

The bill would also stabilize future replacement rates (benefits as a percentage of earnings) in relation to future wage levels, as would have occurred under the assumptions made at the time of the 1972 legislation providing for the automatic adjustment of the social security system to changes in the economy. The major elements of the revised benefit structure are:

1. Each worker's wages and the social security benefit formula would be indexed to reflect changes in wage levels up to the time he reaches age 62, becomes disabled, or dies to assure that future replacement rates would be relatively constant.
2. The benefit formula would provide somewhat lower replacement rates than now prevail—about 5 percent below the estimated 1979 level—and a 10-year transitional guarantee would be provided to assure that workers now approaching age 62 will get at least as much as the benefit table in the law at implementation (1979) would have provided.
3. As under present law, benefits would continue to be increased according to the increases in the cost of living after a person reached age 62 or became disabled and, in the case of the survivor's benefits, after the time of the worker's death.

In addition, the bill provides for changing the relationship between the minimum benefit, which is increasingly paid as a "windfall" to people who did not work regularly under the social security program, and the special minimum benefit, which is provided for long-term, regular workers with low earnings under the program. Specifically—

A. The minimum benefit would be frozen for future beneficiaries at its 1979 dollar amount (about $121.00) and would increase as the cost of living rises only after a person starts getting benefits; and

B. The special minimum would be brought up to date with price increases since it was last adjusted (1973) and automatically kept up with prices in the future.

C. COVERAGE

It has long been recognized that the primary objective of the social security program, preventing dependency, can best be achieved if coverage under the program is compulsory and as universal as possible. To further this objective, your committee's bill would extend coverage to some 6 million jobs in Federal civilian, State and local, and nonprofit organization employment, which would result in nearly universal coverage. About 97 percent of the jobs in paid employment would then be covered.

Your committee has been concerned for some time because some workers are not eligible for retirement benefits under any system or are eligible for inadequate benefits and because windfall social security benefits occur when some workers are not covered under social security and some workers who are covered, but on an elective basis, may terminate their social security coverage. While there were valid

(3) by adding at the end thereof the following new paragraph:

42 USC 611.
26 USC 3304.

"(29) effective October 1, 1979, provided that wage information available from the Social Security Administration under the provisions of section 411 of this Act, and wage information available (under the provisions of section 3304(a)(16) of the Federal Unemployment Tax Act) from agencies administering State unemployment compensation laws, shall be requested and utilized to the extent permitted under the provisions of such sections; except that the State shall not be required to request such information from the Social Security Administration where such information is available from the agency administering the State unemployment compensation laws.".

Effective date.
42 USC 602 note.

(d) The amendments made by this section shall be effective on the date of the enactment of this Act.

STATE DEMONSTRATION PROJECTS

42 USC 1315.

SEC. 404. Section 1115 of the Social Security Act is amended—

(1) by inserting "(a)" after "SEC. 1115.";

(2) by redesignating subsections (a) and (b) as paragraphs (1) and (2), respectively; and

(3) by adding at the end thereof the following new subsection:

42 USC 601.

"(b)(1) In order to permit the States to achieve more efficient and effective use of funds for public assistance, to reduce dependency, and to improve the living conditions and increase the incomes of individuals who are recipients of public assistance, any State having an approved plan under part A of title IV may, subject to the provisions of this subsection, establish and conduct not more than three demonstration projects. In establishing and conducting any such project the State shall—

"(A) provide that not more than one such project be conducted on a statewide basis;

"(B) provide that in making arrangements for public service employment—

"(i) appropriate standards for the health, safety, and other conditions applicable to the performance of work and training on such project are established and will be maintained,

"(ii) such project will not result in the displacement of employed workers,

"(iii) each participant in such project shall be compensated for work performed by him at an hourly rate equal to the prevailing hourly wage for similar work in the locality where the participant performs such work (and, for purposes of this clause, benefits payable under the State's plan approved under part A of title IV of the family of which such participant is a member shall be regarded as compensation for work performed by such participant),

"(iv) with respect to such project the conditions of work, training, education, and employment are reasonable in the light of such factors as the type of work, geographical region, and proficiency of the participant, and

"(v) appropriate workmen's compensation protection is provided to all participants; and

"(C) provide that participation in such project by any individual receiving aid to families with dependent children be voluntary.

"(2) Any State which establishes and conducts demonstration projects under this subsection may, subject to paragraph (3), with respect to any such project—

"(A) waive, subject to paragraph (3), any or all of the requirements of sections 402(a)(1) (relating to statewide operation), 402(a)(3) (relating to administration by a single State agency), 402(a)(8) (relating to disregard of earned income), except that no such waiver of 402(a)(8) shall operate to waive any amount in excess of one-half of the earned income of any individual, and 402(a)(19) (relating to the work incentive program);

42 USC 602.

"(B) subject to paragraph (4), use to cover the costs of the project such funds as are appropriated for payment to such State with respect to the assistance which is or would, except for participation in a project under this subsection, be payable to individuals participating in such projects under part A of title IV for any fiscal year in which such projects are conducted; and

"(C) use such funds as are appropriated for payments to States under the State and Local Fiscal Assistance Act of 1972 for any fiscal year in which the project is conducted to cover so much of the costs of salaries for individuals participating in public service employment as is not covered through the use of funds made available under subparagraph (B).

31 USC 1221 note.

Application.

"(3)(A) Any State which wishes to establish and conduct demonstration projects under the provisions of this subsection shall submit an application to the Secretary in such form and containing such information as the Secretary may require. Whenever any State submits such an application to the Secretary, it shall at the same time issue public notice of that fact together with a general description of the project with respect to which the application is submitted, and shall invite comment thereon from interested parties and comments thereon may be submitted, within the 30-day period beginning with the date the application is submitted to the Secretary, to the State or the Secretary by such parties. The State shall also make copies of the application available for public inspection. The Secretary shall also immediately publish a summary of the proposed project, make copies of the application available for public inspection, and receive and consider comments submitted with respect to the application. A State shall be authorized to proceed with a project submitted under this subsection—

Notice.

Copies, public inspection.

"(i) when such application has been approved by the Secretary (which shall be no earlier than 30 days following the date the application is submitted to him), or

"(ii) 60 days after the date on which such application is submitted to the Secretary unless, during such 60 day period, he denies the application.

"(B) Notwithstanding the provisions of paragraph (2)(A), the Secretary may review any waiver made by a State under such paragraph. Upon a finding that any such waiver is inconsistent with the purposes of this subsection and the purposes of part A of title IV, the Secretary may disapprove such waiver. The project with respect to which any such disapproved waiver was made shall be terminated by such State not later than the last day of the month following the month in which such waiver was disapproved.

42 USC 601.

reasons for the special coverage exclusions and provisions enacted for these workers, your committee believes these reasons are no longer compelling and that the workers should be treated as are the great majority of the Nation's work force, who are compulsorily covered under social security and who do not have the right to terminate their coverage. This coverage would not be effective until 1982 to allow for adjustment of governmental staff retirement systems to take into account social security protection and taxes.

D. GENDER-BASED DISTINCTIONS AND TREATMENT OF SPOUSES

Your committee is concerned that the social security program provides adequate protection in terms of the needs of today's society and that women, as well as men, be treated equitably under the program. Therefore, your committee has directed the Secretary of Health, Education, and Welfare to carry out a detailed study of alternative proposals to (1) eliminate dependency as a requirement for entitlement to social security spouse's benefits, and (2) bring about, in practical terms, equal treatment of men and women under social security, taking into account relevant social and economic factors. However, without awaiting the results of this study (due 6 months from the date of enactment), your committee has adopted measures that move in this direction—

A. The gender-based differences of treatment for men and women under present law would be eliminated; and

B. Protection for spouses would be improved by (1) shortening the duration-of-marriage requirement for aged divorced spouse's benefits from 20 years to 5, and (2) providing that marriage or remarriage will not adversely affect a person's rights to dependents or survivors spouse's benefits.

E. RETIREMENT TEST

The bill would provide improvements in the provisions of the law which cause a reduction in benefit payments when an individual has significant earnings by—

A. Increasing the annual amount of earnings a beneficiary age 65 or older may have without having any benefits withheld to $4,000 for 1978 and $4,500 for 1979; and

B. Elimination of the monthly measure of retirement—the provision under which benefits may be payable for months in which earnings are low, regardless of total earnings for the year.

F. OTHER PROVISIONS

In addition, your committee's bill would provide for a number of other improvements in the social security cash benefits program.

G. INCOME AND BENEFITS EFFECTS OF THE BILL

The following table shows the effects of the provisions of your committee's bill in terms of benefit outgo and additional income. The net effect of the bill is shown on the bottom line of the table.

ESTIMATED EFFECTS OF H.R. 9346 ON THE NET INCREASE IN THE OASI AND DI TRUST FUNDS, COMBINED, IN CALENDAR YEARS 1978–83, BY PROVISION

[In millions of dollars]

	Effective date	1978	1979	1980	1981	1982	1983
REDUCTION IN BENEFIT PAYMENTS							
Decoupling, with 3 percent delayed retirement credits.	January 1979		70	351	803	1,473	2,377
Elimination of marriage or remarriage as a bar to entitlement to benefits.	do		−1,135	−1,355	−1,454	−1,551	−1,654
Reduction in duration of marriage required for divorced spouses benefits from 20 yr to 5 yr.	do		−137	−164	−177	−190	−204
Changes in retirement test (total)	January 1978	−54	−266	−328	−346	−367	−390
Increase annual exempt amount to $4,000 in 1978 and to $4,500 in 1979.	do	−267	−491	−554	−582	−611	−642
Eliminate the monthly measure	do	213	225	226	236	244	252
Eliminate retroactive payments of actuarially reduced benefits.	do	339	536	550	559	565	569
Increase special minimum benefit from $9 per year of coverage to $11.50, and apply automatic increases in the future.	January 1979		−12	−14	−14	−15	−16
Changes in annual wage reporting provisions	January 1978	(1)	−1	−4	−9	−18	−26
Eliminate gender-based distinctions from the law.	do	−4	−5	−6	−7	−8	−8
Limit increases in actuarially reduced benefits	do	90	280	500	751	948	1,157
Increase in contribution and benefit base	do	(1)	−12	−44	−112	−209	−346
Subtotal, excluding universal coverage		371	−682	−514	−6	628	1,459
Universal coverage of Federal civilian employees, employees of State and local governments, and employees of nonprofit organizations.	January 1982					(1)	−94
Total reduction in benefit payments		371	−682	−514	−6	628	1,365
ADDITIONAL INCOME							
Contribution income resulting from financing changes.	January 1978	3,967	6,661	8,560	11,858	13,265	14,060
Contribution income resulting from universal coverage.	January 1982					11,741	14,231
Additional interest income		113	475	1,005	1,786	3,132	5,343
Total additional income		4,080	7,136	9,565	13,644	28,138	33,634
Net effect of bill		4,451	6,454	9,051	13,638	28,766	34,999

[1] Less than $500,000.

II. Summary of Principal Provisions of the Bill

A. FINANCING

Consistent with the policy of your committee and the Congress to maintain the social security program on a sound financial basis, the bill would make provision for strengthening both the short- and long-range financial stability of the program, including meeting the cost of the benefit improvements recommended by your committee. To accomplish those purposes, your committee's bill would increase the contribution and benefit base (the maximum amount of a worker's annual earnings that is subject to social security taxes and creditable for benefits), revise the schedule of tax rates in the law, reallocate a portion of scheduled increases in the hospital insurance (HI) tax rate to the cash benefits (OASDI) program, and increase the future tax rates scheduled in the law. In addition, the bill would provide for standby authority for loans to the OASI and DI trust funds from Federal general revenues in the event—not contemplated in this century under current actuarial estimates—that trust fund levels fall below specified minimum levels.

1. Increase in contribution and benefit base

Your committee's bill provides for increasing the contribution and benefit base—in four steps—to a level where about 90 percent of all payroll in covered employment would be taxable for social security purposes (and about 93 percent of all workers would have their full earnings credited for benefit purposes). Accordingly, the bill would increase the base to $19,900 in 1978, $22,900 in 1979, $25,900 in 1980, and $27,900 in 1981, with automatic adjustments to keep up with average wage levels thereafter (as under present law).

2. Changes in OASDHI contribution rates

Your committee has included provisions for allocating a small portion of future income from currently scheduled HI tax-rate increases to the OASDI program. In addition, tax rates for the OASDI program for employers and employees, each, would be increased (beyond the increases resulting from reallocation of scheduled HI tax-rate increases, which do not result in any net OASDHI tax rate increase over present law).

Specifically, the reallocations from HI to OASDI would be 0.1 percent each for 1978–80 and 0.05 percent each for 1981 and after. Also, the OASDI contribution rates would be further increased from 5.0 percent each, by 0.15 percent each in 1981, an additional 0.30 percent each in 1985, and another 0.55 percent each for 1990–2010. The reallocations plus the rate increases result in OASDI rates of 5.05 percent for 1979–80, 5.15 percent for 1981–84, 5.45 percent for 1985–89, and 6 percent for 1990 and after.

3. Changes in self-employed contribution rates for OASDI

Your committee's bill would restore the self-employed rate to its original level of one and one-half times the employee rate, effective in 1981. (Since 1972, the social security cash benefits contribution rate for the self-employed has been below the level of one and one-half times the employee rate that was originally provided when the self-employed were first covered under the social security program in 1951.)

4. Change in allocation to the disability insurance trust fund

The committee bill would allocate an additional 0.25 percent of taxable payroll in the early years and even higher additional allocations in later years to the disability insurance trust fund to assure the financial soundness of the disability insurance program.

5. Standby authority for loans to the OASDI trust funds from general revenues with repayment tax provision

Your committee is especially concerned about the need for the public—current and future workers as well as social security beneficiaries—to be assured that the program will be able to meet its benefit obligations at all times. While the other actions your committee has taken would restore the financial soundness of the program, your committee believes that a further guarantee of the future financial stability of the cash benefit program is necessary.

Accordingly, your committee has included provision granting standby authority for automatic loans to the social security cash benefit trust funds from Federal general revenues whenever the assets of a cash trust funds drop below a 25-percent level of outgo. Your committee emphasizes its belief that, under reasonable projections, it will not become necessary for such loans to the trust funds to be made. If such loans are made in the future, the committee bill would provide for temporary social security tax-rate increases of 0.1 percent for employees and employers, each, and 0.15 percent for the self-employed, when the reserve level is 24 percent or less and the loan debt exceeds $2 billion, to provide funds to repay the loans; repayment would begin when the reserve level rises above 30 percent.

B. REVISED BENEFIT STRUCTURE

About half of the existing long-range deficit in the OASDI program is the result of unintended effects of the cost-of-living increase provisions of present law. The basic problem under the present benefit structure is that future benefits for current workers will reflect increases in both wages and prices that occur during their working years. As a result, replacement rates—initial benefits as a percent of preretirement earnings—are erratic and unpredictable and, under current long range economic assumptions, are projected to rise significantly over time. About one-half of the long-range deficit is due to rising replacement rates in the future.

The bill would prevent the unintended rise in future replacement rates (and costs), and assure that future replacement rates would remain fairly constant at a level approximately 5 percent lower than the level that will prevail in January 1979. A major feature of the plan is that the worker's earnings (and the benefit formula) would be indexed to reflect the change in wage levels that has occurred during his working lifetime. As a result, benefits would be based on the worker's relative earnings position averaged over his working lifetime.

1. Wage indexing of earnings

A worker's earnings would be updated (indexed) to just prior to when the worker reaches age 62, becomes disabled, or dies to reflect the increases in average wages that have occurred since the earnings were paid. (Under present law, a worker's earnings are counted in actual dollar value.) The worker's earnings would be indexed by multiplying the actual earnings by the ratio of average wages in the second year before he reaches age 62, becomes disabled, or dies to the average wages in the year being updated.

2. Base year for indexing

A worker's earnings would be indexed by average wage increases through the second year before age 62 (the age of first eligibility), disability, or death. Earnings after age 62 or disability would be counted in actual dollar amount; cost-of-living increases would apply beginning with age 62, disability, or death.

3. Computation period

Benefits would be based on a worker's indexed earnings averaged over the number of years after 1950 (or age 21, if later) up to the year he reaches age 62, becomes disabled, or dies, whichever occurs first (excluding 5 years of lowest indexed earnings or no earnings). As under present law, the computation period would expand from 23 years for those reaching age 62 in 1979, up to 35 years for those reaching age 62 in 1991 or later.

4. Benefit formula

The benefit formula shown below would be applied to the average indexed monthly earnings (AIME) of workers who reach age 62, become disabled, or die in 1979:

90 percent of the first $180 of AIME, plus
32 percent of AIME over $180 through AIME of $1,085, plus
15 percent of AIME above $1,085.

For those who become eligible for benefits in the future, the dollar amounts (bend points) in the formula would be adjusted automatically (and rounded to the nearest dollar) as average wages increase.

5. Maximum family benefit

Maximum family benefits would bear the same relationship to primary insurance amounts (PIA) as they do under present law—ranging from 150 percent to 188 percent of the PIA. The family maximum would be determined by applying the following formula to the worker's PIA:

150 percent of the first $230 PIA, plus
272 percent of PIA's over $230 through $332, plus
134 percent of PIA's over $332 through $433, plus
175 percent of PIA's above $433.

In the future, the dollar amounts in the formula would be increased (and rounded to the nearest dollar) based on increases in average wages.

6. Transition

A worker who reaches age 62 after 1978 and before 1989 would be guaranteed a benefit no lower than he would have received under present law as of January 1979. For purposes of the guarantee, the January 1979 benefit table would not be subject to future automatic benefit increases, but all individual benefits would be subject to all cost-of-living increases in benefits beginning with age 62. This guarantee would not apply in disability and death cases.

7. Treatment of earnings after age 62 or disability

Earnings subsequent to the year of first eligibility (age 62) or onset of disability would be counted at actual dollar value (i.e., unindexed) and substituted for earlier years of indexed earnings if they would increase the worker's AIME and his PIA.

8. Increase in delayed retirement credit

For workers reaching age 62 after 1978, the current delayed retirement credit of 1 percent per year would be increased to 3 percent per year beginning at age 65 and taking account of months up to age 72 for which benefits are not paid. (For workers eligible for retirement benefits before 1979, the current 1-percent per year credit would continue to apply.)

Estimated number of people affected and dollar payments: In 1983 (the first year increased benefits reflecting the 3-percent delayed retirement credits would be payable based on credits provided for 1982), 100,000 people would get higher benefits, and $15 million in additional payments would be made as a result of this provision.

9. Freeze the minimum benefit

The minimum benefit for future beneficiaries would be frozen at an amount equal to the minimum benefit in effect in January 1979 (estimated to be about $121). Benefits based on the minimum would be kept up to date with rising prices only after age 62, disability, or death.

Estimated number of people affected and dollar payment: Some 150,000 people would be affected by this amendment, and benefit payments would be reduced by an estimated $7 million in the first full calendar year, 1980.

10. Increase in the special minimum benefit

Under present law, a special minimum benefit is provided for long-term, low-paid workers equal to $9 times the number of years of coverage a worker has in excess of 10 and up to 30; the special minimum benefit is not subject to cost-of-living increases under the automatic adjustment provisions. The bill would increase the $9 figure to $11.50 and provide that the special minimum would be kept up to date with future increases in the cost of living for both present and future beneficiaries. Thus, the highest possible special minimum would be increased from $180 to $230 in 1979.

Estimated number of people affected and dollar payments: 220,000 people would get increased benefits on the effective date, and additional benefit payments in the first full calendar year, 1980, would amount to an estimated $14 million.

C. COVERAGE

Old-age, survivors, disability, and hospital insurance coverage would be extended to an additional 6 million jobs.

1. Federal civilian employees

Under present law, services performed in Federal civilian employment that are covered under a staff-retirement system established by a law of the United States are excluded from social security coverage, as are services performed in Federal employment by the President, the Vice President, Members of the U.S. Congress, legislative employees of the U.S. Congress, inmates of Federal penal institutions, certain student employees of Federal hospitals, and temporary, emergency employees. The bill would extend social security coverage to Federal services performed by these offices and employees. The bill directs the Secretary of Health, Education, and Welfare to conduct a study with the Civil Service Commission to make recommendations for coordinating benefits and costs of the OASDI and Civil Service Retirement programs in such a way that Federal workers will be no worse off so far as costs and benefits are concerned compared to their treatment under present law. The report would be submitted by January 1, 1980.

Effective date: January 1, 1982.

2. State and local employees

Under present law, social security coverage for State and local employees generally is available only on a group basis through voluntary agreements between the States and the Secretary of Health, Education, and Welfare. Coverage for a group of State and local employees can be terminated after 2 years' notice by the State if the group has been covered under social security for 5 years at the time notice is given, or by the Secretary at any time, if he finds that the State has failed or is unable legally to comply with the terms of the agreement and 2 years' notice is given. The bill would provide compulsory social security coverage for State and local employees (including employees of Guam, American Samoa, and the District of Columbia) who are not compulsorily covered under present law.

Effective date: January 1, 1982.

The bill also would provide that coverage could not be terminated by either the State or the Secretary of Health, Education, and Welfare before compulsory coverage was effective unless the notice was given before September 14, 1977. In such cases where coverage has been terminated it would be restored effective January 1, 1982.

Effective date: September 14, 1977.

3. Employees of nonprofit organizations

Under present law, employees of certain nonprofit organizations, described in section 501(c)(3) of the Internal Revene Code, are excluded from coverage under social security unless the organization files a certificate expressing a desire to have coverage extended to its employees. Coverage of the employees of an organization that filed such a certificate may be terminated after 2 years' notice by the organization, if the employees had been covered under social security for at least 8 years before the notice was given, or by the Secretary of the Treasury, with concurrence of the Secretary of Health, Education, and Welfare, at any time if he finds that the organization has failed or is unable to comply with the law and 60 days' notice is given. The bill would provide compulsory coverage under social security for these employees of nonprofit organizations.

Effective date: January 1, 1982.

The bill also would provide that coverage could not be terminated by either the nonprofit organization or the Secretary of the Treasury before compulsory coverage was effective unless the notice was given before September 14, 1977. In such cases where coverage has been terminated, it would begin again on January 1, 1982.

Effective date: September 14, 1977.

4. Quarter-of-coverage provision

The bill would grant retroactive quarter-of-coverage credits for eligibility, but not benefit computation purposes, to employees who were in Federal civilian, State, or local, or nonprofit organization employment to which social security coverage was extended under this bill on January 1, 1982, if the employees earned at least six quarters of coverage in such employment after 1981. The quarters of coverage would be granted based on periods of employment prior to January 1, 1982, which were in the same category of employment and which were excluded from social security coverage.

Effective date: January 1, 1982.

5. Totalization

Under present law, there is no authority in the Social Security Act for entering into agreements with other countries to provide for coordination between the social security systems of the United States and of other countries. The bill would authorize the President to enter into bilateral agreements (of a kind generally known as totalization agreements) with interested foreign countries to provide for limited coordination between this country's social security system and those of other countries, subject to congressional oversight. Draft agreements worked out with Italy and West Germany have been implemented by their laws but cannot become effective agreements in the United States until the Congress enacts the authority provided in this bill.

Effective date: Upon enactment.

6. Exclusion of limited partnership income

Under present law each partner's share of partnership income is includable in his net earnings from self-employment for social security purposes, irrespective of the nature of his membership in the partnership. The bill would exclude from social security coverage, the distributive share of income or loss received by a limited partner from the trade or business of a limited partnership. This is to exclude for coverage purposes certain earnings which are basically of an investment nature. However, the exclusion from coverage would not extend to guaranteed payments (as described in section 707(c) of the Internal Revenue Code), such as salary and professional fees, received for services actually performed by the limited partner for the partnership.

Effective date: Taxable years beginning after December 31, 1977.

7. Social security employer taxes on tips when deemed as wages for the Federal minimum wage

Under the Fair Labor Standards Act of 1938, an employer can pay an employee less than the Federal minimum wage by an amount equal to the tips received by the employee but not less than 50 percent of the minimum wage. Social security taxes are not paid by the employer on the amount of tips deemed to be wages. Under the bill, employers would be liable for the employers' share of the social security taxes on the deemed wages up to the minimum wage.

Effective date: Wages paid for employment performed after December 31, 1977.

8. Clergymen

Under present law, the services of a clergyman are covered under the self-employment provisions of the Social Security Act unless the clergyman files an application for an irrevocable exemption from coverage on the grounds that he is opposed either conscientiously or because of religious principles to the acceptance of public insurance such as social security. Under the bill, a clergyman who filed an application for exemption in the past would be given an opportunity to revoke his exemption and obtain social security coverage prospectively.

Effective date: Taxable years ending on or after enactment.

9. Other State and local changes

Other changes relate to social security coverage of policemen and firemen in Mississippi and Illinois who are under staff retirement systems, and social security coverage of State and local employees in New Jersey under the divided retirement system procedure, and the special provision in the law applying to the Wisconsin retirement fund.

Effective date: Upon enactment.

D. EQUAL TREATMENT OF MEN AND WOMEN

1. *Equal rights*

a. Father's benefits

Benefits would be provided for young husbands and fathers who have in their care a child who is under age 18, or disabled, and who is entitled to benefits.

Effective date: Effective with respect to benefits for months after December 1977.

Estimated number of people affected and dollar payments: 2,000 people would become eligible for benefits or eligible for larger benefits on the effective date. About $2 million in additional benefits would be paid in the first full year of operation.

b. Benefits for divorced men

Benefits would be provided for aged divorced husbands and aged or disabled divorced widowers.

Effective date: Effective with respect to benefits for months after December 1977.

Estimated number of people affected and dollar payments: 2,000 people would become eligible for benefits or eligible for larger benefits on the effective date. About $3 million in additional benefits would be paid in the first full year of operation.

c. Remarriage of widowers before age 60

A widower would be permitted to obtain benefits on a deceased wife's earnings record if he is not married at the time he applies for widower's benefits, as widows now can, instead of if he has not remarried, as present law provides.

Effective date: Effective with respect to benefits for months after December 1977.

Estimated number of people affected and dollar payments: Very few people would be affected and the additional benefits would be negligible.

d. Transitional insured status benefits

Husband's and widower's benefits would be provided under the transitionally insured status amendment of 1965.

Effective date: Effective with respect to benefits for months after December 1977.

Estimated number of people affected and dollar payments: Very few people would be affected and the additional payments would be negligible.

e. Special age-72 payment amounts for certain uninsured individuals

When both members of a couple are receiving special age-72 payments, the amount of the payments would be divided equally between the two, instead of giving the husband a full benefit and the wife one-half the husband's benefit.

Effective date: Effective with respect to benefits for months after December 1977.

Estimated number of people affected and dollar payments: 2,000 couples would be affected. Provision would have no cost.

f. *Benefits of spouses of childhood disability or disabled worker beneficiaries*

Benefits of the spouse of a female disabled worker beneficiary or childhood disability beneficiary would be terminated if she ceases to be disabled, as is now the case if the disabled worker or childhood disability beneficiary is a male. (Beneficiaries whose benefits are terminated under this provision would be able to become reentitled to benefits as a result of provisions eliminating marriage or remarriage as a factor in terminating or reducing benefits, which has a later effective date.)

Effective date: Effective with respect to benefits for months after December 1977.

Estimated number of people affected and dollar payments: The number of people affected would be very small and the payments would be negligible.

g. *Benefit rights of illegitimate children*

An illegitimate child's status for purposes of entitlement to child's insurance benefits would be determined with respect to the child's mother in the same way as it is now determined with respect to the child's father.

Effective date: Effective with respect to benefit for months after December 1977.

Estimated number of people affected and dollar payments: Very few people would be affected and the additional payments would be negligible.

h. *Waiver of civil service survivors' annuities*

A widower, as well as a widow, would be permitted to waive payment of a Federal benefit attributable to credit for military service performed before 1957 in order to have the military service credited toward eligibility for, or the amount of, a social security benefit.

Effective date: Effective with respect to benefits for months after December 1977.

Estimated number of people affected and dollar payments: A negligible number of people would be affected. The provision would have no cost.

i. *Crediting of self-employment income in community property States*

The self-employment income of a married couple in a community property State would be credited for social security purposes to the spouse who exercises more management and control over the trade or business, instead of being deemed the husband's, unless the wife exercises substantially all of the management and control of the business, as present law provides. Where the husband and wife exercised the same amount of management and control, the self-employment income would be divided equally between both the husband and wife.

Effective date: Effective with respect to taxable years beginning after December 1977.

Estimated number of people affected and dollar payments: A negligible number of people would be affected. Provision would have no cost.

2. Elimination of marriage (or remarriage) as a bar to entitlement to dependents' or survivors' benefits, and as an event which terminates entitlement to, or reduces, such benefits.

Entitlement to benefits as a divorced wife or husband, widow or widower, or surviving divorced widow or widower (including those with an entitled child in their care), parent, or child would not be barred or terminated because of marriage or remarriage. Neither would remarriage serve to cause any reduction in the benefits paid aged widows or widowers.

Effective date: Effective with respect to benefits for months after December 1978.

Estimated number of people affected and dollar payments: 670,000 people would become eligible for benefits or eligible for larger benefits on the effective date. About $1.4 billion in additional benefits would be paid in the first full calendar year, 1980.

3. Reduced duration-of-marriage requirement for divorced spouses.

The length of time a divorced person must have been married to a worker in order for benefits to be payable to the person as an aged divorced spouse or aged or disabled surviving divorced spouse would be reduced from 20 years to 5.

Effective date: Effective with respect to benefits for months after December 1978.

Estimated number of people affected and dollar payments: 70,000 people would become eligible for benefits or eligible for larger benefits on the effective date. About $160 million in additional benefits would be paid in the first full calendar year, 1980.

4. Study of proposals to eliminate dependency and sex discrimination

The Secretary of Health, Education, and Welfare would be directed to carry out a detailed study of proposals (1) to eliminate dependency as a requirement for entitlement to social security spouse's benefits, and (2) to bring about the equal treatment of men and women (in any and all respects under the program). A full and complete report on the study shall be submitted to the Congress within 6 months of enactment of the bill.

E. IMPROVEMENT OF THE EARNINGS TEST

1. Increase in annual exempt amount of earnings

The amount that a beneficiary age 65 or over but under age 72 may earn in a year and still be paid full social security benefits for the year would be increased from the present $3,000 in 1977 to $4,000 in 1978 and $4,500 in 1979 with future automatic increases as wage levels rise. The amount that a beneficiary under age 65 could earn and still be paid full benefits would be determined under present law.

Effective date: Taxable years ending after December 1977.

Number of people affected and dollar payments: For 1978, 800,000 people would receive increased payments; 100,000 people who get no payments under present law could get some payment. For 1979, 800,000 people would receive increased payments; 100,000 people who get no payments under present law could get some payments. Additional benefits amounting to $0.3 billion would be paid out in 1978 and $0.5 billion in 1979.

2. Elimination of the monthly earnings test

Under present law, full benefits are paid to a beneficiary, regardless of the amount of annual earnings, for any month in which the beneficiary neither works for wages in excess of the monthly measure ($250 in 1977; more in later years) nor renders substantial services in self-employment. The bill would eliminate the monthly measure of retirement and convert the retirement test to a strictly annual test for years after the initial year of retirement.

Effective date: Taxable years ending after December 1977.

Number of people affected and dollar payments: About 250,000 people would be affected during the first full year. Benefit payments would be reduced by about $0.2 billion each year.

3. Foreign work test

The number of days that a beneficiary under age 72 who works outside the United States in noncovered employment can work in a month and still be eligible for a benefit for that month would be increased from 6 to 8 in 1978 and to 11 in 1979 and thereafter.

Number of people affected and dollar payments: It is estimated that the proposed changes would be a liberalization for about one-half of the 1,500 beneficiaries (out of the approximately 300,000 beneficiaries who live in foreign nations) who now lose benefits because of work activity.

The cost of such a change would be negligible.

F. ANNUAL WAGE REPORTING

Under present law, employers will report their employees' wages for social security and income tax purposes annually on forms W-2 beginning with wages paid in 1978. Employers are required to report quarterly wage data on the forms W-2 to enable the Social Security Administration to determine whether a worker has enough quarters of coverage to be eligible for social security benefits. The bill would change the quarter-of-coverage measure and certain automatic provisions of the social security law so that annual data would be used, instead of quarterly data. Under the bill, employers would no longer have to report quarterly data on the forms W-2 and they and the Government would realize the maximum advantages that annual reporting was designed to achieve.

The most significant program change would be a provision setting out how annual wages would be credited in terms of quarters of coverage. Under present law, a worker generally receives credit for a quarter of coverage for a calendar quarter in which he received at least $50 in wages. Under your committee bill, a worker would receive one quarter of coverage (up to a total of four) for each $250 of earnings in a year, and the $250 measure would be increased automatically every year to take account of increases in average wages.

Effective date: January 1, 1978.

G. OTHER PROVISIONS

1. Eliminate windfall cost-of-living increases

Under your committee's bill, future benefit increases for people receiving actuarially reduced benefits, would be reduced in proportion to the reduction in the person's basic benefit. (Under present law, the failure to fully reduce the amount of the increase results in increases beyond those needed to keep up with changes in the cost of living.) The provision would apply to people who receive reduced benefits after December 1977; special rules would apply to those already on the rolls.

Effective date: Benefit increases after 1977.

Estimated number of people affected and dollar payments: About 15 million people would have their benefits affected by the provision at the time of the June, 1978 cost-of-living benefit increase, and there would be a program saving of $90 million in calendar year 1978.

2. *Limitation on retroactive benefits*

Under present law, a person who files an application after he is first eligible for benefits may be paid benefits, including actuarially reduced benefits, for a retroactive period up to 12 months before the month in which the application is filed, if all conditions of entitlement are met for those months. Under the bill, except in those cases where the benefits were disability-related or where unreduced dependents benefits were involved, monthly cash benefits would not be paid retroactively for months before the month in which the application was filed when such retroactivity would result in permanently reduced benefits.

Effective date: With applications filed on or after January 1, 1978.

Number of people affected and dollar payments: In 1978, an estimated 1 million people would be affected by the change. Reductions in benefit payments would range from $0.3 billion in 1978 to $0.6 billion in 1982.

3. *Early payment of social security and SSI benefit checks in certain situations*

Under present law, social security benefit payments for a particular month are payable after the end of that month, and payment is normally made on the third day of the month; SSI benefit checks for a particular month are delivered on the first day of that month. Under the bill, when the delivery date falls on a Saturday, Sunday, or legal public holiday, social security and SSI checks would be delivered on an earlier date.

Effective date: Upon enactment.

III. General Discussion

A. FINANCING

Over the years your committee and the Congress have devoted more attention to financing than any other aspect of the social security program in order to assure that funds will be available to meet benefit payments as they fall due. Whenever benefit improvements have been enacted, your committee has recommended, and the Congress has provided, financing arrangements that, based on the best available economic and demographic assumptions, assured the future financial soundness of the program over the long-range future.

When the Congress last enacted major social security legislation, in 1973, the program was adequately financed, both in the short run and over the long term, based on then-current assumptions which were considered reasonable by economists and actuaries at that time. It was assumed at that time that over the long range wages would rise at an average annual rate of 5 percent and prices at an average annual rate of 2¾ percent and that the fertility rate would be around 2.5.[1]

Under these assumptions, trust fund levels would have stabilized around 1978 at about 60–65 percent of a year's outgo; over the long term, the estimated actuarial balance was about −0.5 percent of taxable payroll, which was not unreasonable, given the inherent uncertainty of making economic and demographic assumptions for a dynamic system with built-in cost-of-living increases over a 75-year period.

Since 1973, the Nation has experienced much higher rates of inflation and unemployment as well as declines in the fertility rate and real wage growth. As a result of recent and current economic experience, the social security trust funds have been experiencing annual deficits since 1975 and deficits are projected to continue in the future. In addition, the assumptions on which estimates of social security income and outgo over the long term are based have been revised to reflect what now is considered a more realistic view of the future. As a result, the long-range deficit has increased to over 8 percent of taxable payroll.

The recent sharp decline in birth rates means that the number of people working and paying social security contributions in the future will be smaller in relation to the number of people drawing social security benefits. For example, today there are about three workers for every person getting social security benefits; in the next century, it is expected that there will be only about two workers for every beneficiary. Consequently, the cost of the program per worker will rise.

About half of the long-range deficit under present law is due to revised demographic assumptions and the other half is the effect of changes in the long-range economic assumptions on replacement rates—initial benefit levels as a percent of pre-retirement earnings.

Whereas replacement rates would have been relatively constant in the future under the economic assumptions made when the automatic adjustment provisions were enacted in 1972, replacement rates under the revised assumptions are now expected to rise in the future, particularly after the mid-1990's. The decoupling plan proposed by your committee would prevent replacement rates from rising in the future. The proposal would reduce the long-range deficit by more than one-half—from 8.2 percent to 3.49 percent of payroll. However, since the present benefit structure does not have significant cost effects until the mid-1980's and later, decoupling would not impact significantly on benefit outgo until after the mid-1980's and it does not take care of the increased costs due to recent inflation, the decline in the birth rate or the increase in the incidence of disability.

In order to eliminate the short-range deficit due to recent and current economic experience and to reduce the longer-range deficit due to demographic shifts and disability experience, the committee bill includes changes in social security tax rates for employees, employers, and the self-employed, and increases in the contribution and benefit base for employees, employers, and the self-employed.

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[1] High- and low-cost estimates were prepared based on fertility rates of 2.3 and 2.8, respectively.

While the financing provisions of the bill would not completely assure the long-range soundness of the program for all of the customary 75-year valuation period, your committee believes that because there is considerable uncertainty about future demographic and economic developments—changes in birth rates, labor-force participation of women and the aged, and productivity gains—it is not now necessary to take steps to assure the program's financing for the full 75-year period. The legislation eliminates the medium-range deficits (over the next 25) years and provides adequate financing well into the next century. Your committee keeps continuously abreast of developments affecting social security financing and expects to make recommendations in the relatively near future to respond to the recent and unexpected rise in the projected cost of the disability insurance program.

1. Increase in contribution and benefit base

Your committee's bill provides for increasing the contribution and benefit base—in four steps—to a level where about 90 percent of all payroll in covered employment would be taxable for social security purposes (and about 93 percent of all workers would have their full earnings credited for benefit purposes). When the social security program began in 1937, about 92.5 percent of all payroll in covered employment was covered, and about 97 percent of the workers in covered employment had their full earnings counted for benefit purposes. Your committee believes that it would be desirable to move toward taxing a higher proportion of total payroll in covered employment than the 85 percent that is now taxable.

Accordingly, your committee's bill provides for *ad hoc* increases in the contribution and benefit base in 1978, 1979, 1980, and 1981. After 1981, the base would be automatically adjusted to keep up with average wage levels in the same way the present-law base is adjusted. As a result of the automatic adjustment, the proportion of total payroll covered by the base will be eliminated at a constant level over the long run.

The following table shows the contribution and benefit bases projected under present law and under your committee's bill:

Years	Present law	Committee bill
1978	$17,700	[1] $19,900
1979	18,900	[1] 22,900
1980	20,400	[1] 25,900
1981	21,900	[1] 27,900
1982	23,400	30,000
1983	24,900	31,800
1984	26,400	33,600
1985	27,900	35,400
1986	29,400	37,500
1987	31,200	39,600

[1] Ad hoc increases.

Special provisions are included in your committee's bill to exempt the ad hoc earning base increase from tier-II of the Railroad Retirement Act and the Pension Benefit Guaranty Corporation (PBGC). Those provisions are discussed in some detail in item G-4.

2. Changes in OASDHI tax rates

Since raising the contribution and benefit base would result in additional income to the HI program, it is possible, under your committee's bill, to transfer a portion of future tax rate increases already scheduled for HI to the OASDI program, without adversely affecting the status of the HI trust fund. The bill therefore would provide for allocating a portion of future income from HI tax-rate increases already scheduled in the law to the OASDI program as a way of meeting part of currently projected OASDI income shortfalls. Of the 0.20 percent HI tax-rate increase scheduled for employers and employees each in present law for 1978, 0.10 percent would be shifted to OASDI for the years 1978 through 1980, and 0.05 percent would be shifted in 1981 and thereafter.

The tax rates for the OASDI program for employers and employees, each, would be increased (beyond the increases resulting from reallocation of scheduled HI tax-rate increases, which do not result in any net OASDHI tax rate increase over present law) by 0.15 percent, 0.35 percent, and 0.55 percent in 1981, 1985, and 1990, respectively. Thus, by 1990 the overall tax rate increase would amount to a 1.0 percent each, brings the total combined OASDHI tax rates to 7.45 percent each, the level scheduled in present law for the year 2011 and thereafter. The present law rates and the rates under your committee's bill are shown below.

TAX RATES FOR EMPLOYER AND EMPLOYEE, EACH, PRESENT LAW AND COMMITTEE BILL

[In percent]

Years	OASDI		HI		Total	
	Present law	Bill	Present law	Bill	Present law	Bill
1977	4.95	4.95	0.90	0.90	5.85	5.85
1978-80	4.95	5.05	1.10	1.00	6.05	6.05
1981-84	4.95	5.15	1.35	1.30	6.30	6.45
1985	4.95	5.45	1.35	1.30	6.30	6.75
1986-89	4.95	5.45	1.50	1.45	6.45	6.90
1990-2010	4.95	6.00	1.50	1.45	6.45	7.45
2011 and later	5.95	6.00	1.50	1.45	7.45	7.45

3. Changes in self-employed tax rates for OASDI

Your committee's bill provides for changes in the OASDI tax rate applied to self-employment income so as to reestablish the original ratio of 1½ times the employee rate. When the self-employed were first covered under the social security program in 1951, the contribution rate for them for cash benefits was three-fourths of the combined employee-employer rate, which is the equivalent of one and one-half times the rate paid by employees. Since a self-employed person gets the same protection that an employee with the same earnings gets under the program, there is a financial disadvantage to the program in covering the self-employed person, as compared to covering an employee, unless the self-employed person pays contributions at a rate as high as the combined employee-employer rate. On the other hand, though, looked at from the standpoint of an individual contributing toward his own protection, the self-employed individual could easily feel that he was being overcharged if he were required to pay social security contributions over a lifetime at the combined em-

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ployee-employer rate. The self-employed rate of one and one-half times the employee rate that was established when the self-employed were first covered represents a reasonable compromise between these alternatives.

In the last several years, the social security cash benefits contribution rate for the self-employed has been below the level of one and one-half times the employee rate that was originally provided. Your committee believes that the self-employed rate should be restored to its original levels of one and one-half times the employee rate and has included such a change in the bill.

TAX RATES FOR THE SELF-EMPLOYED, PRESENT LAW AND COMMITTEE BILL

[In percent]

Years	OASDI		HI		Total	
	Present law	Bill	Present law	Bill	Present law	Bill
1977	7.00	7.00	0.90	0.90	7.90	7.90
1978-80	7.00	7.10	1.10	1.00	8.10	8.10
1981-84	7.00	7.70	1.35	1.30	8.35	9.00
1985	7.00	8.20	1.35	1.30	8.35	9.50
1986-89	7.00	8.20	1.50	1.45	8.50	9.65
1990 and later	7.00	9.00	1.50	1.45	8.50	10.45

4. Change in allocation to the disability insurance trust fund

The committee bill would revise the allocation of tax income to the disability insurance trust fund, beginning in 1978, to assure the financial soundness of the disability insurance program. The present-law and proposed allocation schedules are shown below:

ALLOCATION TO DISABILITY INSURANCE TRUST FUND

[In percent]

Calendar year	Taxable wages, employer-employee—each		Self-employment income	
	Present law	Bill	Present law	Bill
1977	0.575	0.575	0.815	0.815
1978	0.600	0.775	0.850	1.090
1979-80	.600	.750	.850	1.055
1981-84	.650	.800	.920	1.200
1985	.650	.900	.920	1.350
1986-89	.700	.900	.990	1.350
1990-2010	.700	1.100	.990	1.650
2011 and later	.850	1.100	1.000	1.650

This new re-allocation will increase disability insurance financing by 0.56 percent on a long-term basis.

Your committee realizes the necessity of allocating money to the disability insurance trust fund which could otherwise be exhausted in late 1978. It regrets, however, that it must once again make a re-allocation to this program without dealing legislatively with some of the problems which may be contributing to adverse experience in disability. The decoupling-wage indexing provisions in this bill with no transition guarantee will have the effect of reducing some of the work-disincentive aspects of the current benefit formula. However, action may be necessary in other aspects of the program such as the Federal-

State administrative structure (including the appeals process), the definition of disability, other rehabilitation and work-incentives provisions, and the treatment of the blind as compared to other groups of disabled people. It was decided by the Subcommittee on Social Security that there was not time to go into all the complex issues in disability and enact legislation this year. However, the Subcommittee on Social Security plans to take up disability in phase II of this legislation immediately in the next session. Your committee understands that the Department of Health, Education, and Welfare is exploring various amendments to the disability program and will present them to the Congress early next year. This will help the Subcommittee in finding solutions to these difficult problems.

5. Standby authority for loans to the OASDI trust funds from general revenues

Your committee is especially concerned about the need for the public in general—current and future workers as well as social security beneficiaries—to be assured that the program will be able to meet its benefit obligations at all times. While the other actions your committee has taken would restore the financial soundness of the program into the next century your committee believes that a further guarantee of the future financial stability of the program is necessary.

Accordingly, your committee has included a provision granting standby authority for automatic loans to the OASDI trust funds appropriating funds from Federal general revenues whenever the assets of a cash trust fund drops below a specified level in relation to annual outgo. Specifically, if at the end of any calendar year the assets of the OASI or DI trust fund amounted to less than 25 percent of the outgo from the fund in the calendar year, an automatic loan would be made. The amount of the loan would be equal to the difference between the year-end balance in the fund and 27½ percent of the year's outgo. The loans would be automatically repaid with accrued interest, when assets of the fund at the end of a year exceeded 30 percent of the year's outgo from the fund. To provide for automatic repayment, in case a loan was made, there would be temporary social security tax-rate increases of 0.1 percent for employees and employers, each (0.15 percent for the self-employed), if at the end of any year in which a loan was made the reserve level is less than 35 percent and the loan debt exceeds $2 billion; the temporary tax rate increase would go into effect 1 year later.

Your committee emphasizes its belief that, under reasonable projections, it will not become necessary for such loans to the trust funds to be made in this century. Your committee expects that, if—as is not now anticipated—the loan authority should actually be needed, the Subcommittee on Social Security would immediately meet to consider the financial status of the OASDI program and alternative measures to deal with the situation. Nevertheless, your committee believes—in view of the extensive publicity the financing difficulties of the program have received and the resulting concern about the financial soundness of the program—that an appropriate guarantee such as that recommended by your committee is necessary and desirable.

Under your committee's bill, the standby authority for automatic loans would not be applicable to the HI fund. Even under existing

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law, the HI trust fund balances are adequate for a number of years, and your committee's bill would provide additional revenue to this trust fund. Pending hospital cost containment legislation, if adopted, would have the effect of further strengthening the hospital insurance fund. Moreover, it is expected that the broad issue of health care financing (including financing of protection for beneficiaries of the present medicare program) will be considered when the President's national health insurance proposal is submitted during the second session of this Congress. Accordingly, your committee chose not to extend automatic borrowing authority to the HI fund at this time.

B. REVISED BENEFIT STRUCTURE

A major factor contributing to the long-range deficit is the projected rise in social security benefit replacement rates—initial benefit levels as a percent of prior earnings—under current long-range economic assumptions. This rise in replacement rates causes roughly one-half of the long-range deficit. Current projections show that benefit levels will rise by about 50 percent more than wages over the next 75 years, with most of this increase occurring after the 1990's. Replacement rates can fluctuate widely in the future, either up or down, depending on future changes in wages and prices. When the automatic provisions were enacted in 1972, it was expected, on the basis of the economic assmptions made then, that future replacement rates would remain fairly constant.

The projected increase in replacement rates under present law is due to the fact that benefits for people who will retire in the future will be affected by the changes in both wages and prices that occur during their working years. Their benefits will be affected by the automatic cost-of-living benefit increases, which were provided for by the 1972 social security amendments, since such increases apply to future benefits for current workers as well as the benefits paid to current beneficiaries. A current worker's future benefits will also increase because his earnings are expected to increase as economic growth occurs.

Under your committee's bill, the benefit structure would be "decoupled," that is, current workers' future benefits would be separated from those of beneficiaries currently on the rolls; the automatic cost-of-living increases would apply only to beneficiaries on the rolls when such benefit increases becomes effective. The decoupling proposal provides a new benefit formula for future beneficiaries that would produce replacement rates and costs that are much more predictable than under present law. The benefit amounts payable to workers who retire in the future would generally reflect the increase in the standard of living that occurs during their working years.

A major feature of the plan is that the worker's earnings would be indexed to reflect the change in general wage levels that has occurred during his working lifetime. These indexed earnings would be averaged and a three-step, weighted benefit formula[1] would be applied to his average indexed monthly earnings (AIME) to produce the worker's benefit amount. For those becoming entitled to benefits in the future, the benefit factors (percentage amounts) would not be indexed, but the bend points (dollar amounts) in the formula would be adjusted automatically as average wages increase.

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[1] The formula for 1979 follows:
90 percent of the first $180 of AIME, plus
32 percent of AIME over $180 through AIME of $1,085, plus
15 percent of AIME above $1,085.

By providing for the indexing of earnings and the benefit formula to the increase in general wage levels, benefits would be based on the worker's relative earnings position averaged over his working lifetime. As a result, all workers with the same relative earnings positions would be treated the same regardless of when they become entitled to benefits. Thus, while the dollar amounts of benefits of, say, workers with average earnings retiring 20 or 30 years apart would be substantially different, their replacement rates would be virtually the same.

In addition, your committee recommends that replacement rates be stabilized at a level 5 percent lower than the levels that will prevail in January 1979, when the revised benefit structure will be implemented. This recommendation would result in replacement rates more nearly in line with those that could have been anticipated under the 1972 legislation than those that have in fact occurred. Your committee believes that the gradual increase in replacement rates (and costs) that has occurred was unintended and that replacement rates that existed in recent years should be reestablished and maintained at relatively constant levels in the long-range future.

Your committee's bill would assure that social security benefit protection will generally keep pace with rising wages during the worker's lifetime and with the cost of living after the worker and his family start to receive benefits. This was the underlying premise of the 1972 automatic adjustment provisions and, in fact, the way the system generally operated before the automatic provisions were enacted.

Replacement rates for hypothetical workers at various earnings levels under present law and under the revised benefit structure are shown below. For purposes of illustration, replacement rates are defined as the worker's initial benefit as a percentage of final year earnings. This definition of replacement rates is convenient both for comparing two different benefit structures (present law and the new, revised structure under the committee bill) and for illustrative purposes. However, for purposes of evaluating the effect of the new system on various individuals and groups within the system, lifetime average earnings, indexed to earnings levels (AIME) may be a preferable measure on which to base replacement rates. Because of the effect of ad hoc increases in the contribution and benefit base in the past and those provided under your committee's bill, the replacement rates for the worker with earnings equal to the maximum taxable do not become stabilized for a number of years. The replacement rates appear to rise from 1985 through 2000 if measured in terms of final year earnings, as shown below, but—when measured in terms of average indexed monthly earnings—the replacement rates are shown to fall over this period.

REPLACEMENT RATES: HISTORICAL BEHAVIOR AND PROJECTIONS UNDER PRESENT LAW AND UNDER THE COMMITTEE BILL

[In percent]

Calendar year	Replacement rate for worker with— Low earnings [1]	Average earnings [2]	High earnings [3]
Historical behavior:			
1970	45	33	28
1971	47	35	31
1972	48	36	34
1973	51	39	35
1974	54	41	33
1975	56	43	30
1976	57	45	32
1977	58	44	32
Present law:			
1979	57	44	34
1985	58	47	34
1990	60	48	35
1995	66	49	37
2000	75	52	39
2010	84	56	42
2020	91	60	41
2030	96	63	46
2040	101	65	47
2050	106	67	48
Committee bill:			
1979	[4] 57	[4] 44	[4] 34
1985	55	43	26
1990	55	43	26
1995	55	43	27
2000	55	43	28
2010	55	43	30
2020	55	43	30
2030	55	43	30
2040	55	43	30
2050	55	43	30

[1] Assumed at $4,600 in 1976 and following the trends of the average.
[2] Assumed to be 4 times the average 1st quarter covered earnings.
[3] Assumed at the maximum taxable under the program.
[4] Reflects the benefit guarantee provision in the bill.

Note: The estimates in this table are based on the intermediate set of assumptions used in the 1977 OASDI trustees report. The replacement rates pertain to workers with steady employment at increasing earnings and compare the annual retirement benefit at age 62, ignoring the actuarial reduction factor, with the earnings in the year immediately prior to retirement.

The plan included in your committee's bill necessarily involves many substantial changes in provisions of present law, transitional provisions for the period during which the new system is implemented, and a number of "conforming" amendments to minimize possible disruptions that such a basic change in the benefit structure might otherwise produce.

The key elements of your committee's bill with respect to "decoupling" and the establishment of replacement rates that would be constant in relation to wage levels over time are outlined below.

1. *Wage indexing of earnings*

Your committee's bill would provide that a worker's benefits would be based on earnings levels that prevail just prior to age 62, disability, or death. The worker's earnings in each year after 1950 would be updated (indexed) to reflect the increase in average wages through the second year before the worker reaches age 62, becomes disabled, or dies.[1] Under present law, for the purpose of computing a worker's benefit, his earnings are counted in actual dollar value, and these earnings do not reflect their value relative to average earnings at the time they were earned.

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[1] While it would seem reasonable to update earnings through the first year before the year of retirement, data on actual wage growth will not be available in time to allow for such current indexing. For 1978 and subsequent years, the law provides that earnings will be reported on an annual, rather than a quarterly basis. Thus, for example, data on average wage levels in 1980 will not become available until late in 1981—too late for indexing earnings of 1981 retirees; 1979 would be the indexing year for 1981 retirees.

A worker's earnings would be indexed by multiplying the actual earnings by the ratio of average wages in the second year before he reaches age 62, becomes disabled, or dies, to the average wages in the year being updated. For example, if a worker earned $3,000 in 1956, and retired at age 62 in 1979, the $3,000 would be multiplied by the ratio of average annual wages in 1977 ($10,002) to average annual wages in 1956 ($3,514), as follows:

$$\$3{,}000 \times \frac{\$10{,}002}{\$3{,}514} = \$8{,}539$$

Thus, while the worker's actual earnings for 1956 were $3,000, his relative or indexed earnings would be $8,539. The worker's earnings each year would be adjusted in this manner. The result would be that the worker's benefits would be based on earnings levels that prevail just prior to age 62, and benefits would be based on the worker's relative earnings (that is, relative to average wages) averaged over the time the worker could reasonably be expected to have worked in covered employment.

Under present law, a worker who had above-average earnings in the 1950's and who had below-average earnings in the last 10 years is disadvantaged compared to one who had the reverse earnings pattern. While the two workers might have had the same earnings relative to average earnings over the period as a whole, the worker with the more recent above-average earnings would have higher average monthly earnings and, consequently, a higher benefit. Under the bill, these workers would get the same benefit amount, all other things being equal. Moreover, even if they reach age 62 at different times, they would get benefits that represented the same percent of the preretirment earnings.

In addition, indexing wages as proposed by your committee assures that benefit amounts would generally be related to the standard of living that prevails when the worker retires, becomes disabled, or dies; that is, workers would share in the general rise in the standard of living that occurs during their working lifetimes.

Your committee would also note that this method of indexing the worker's wages (the benefit formula would be similarly indexed) would virtually eliminate the unintended and growing advantage that young disabled workers and their families and the survivors of deceased workers have over retired workers under present law. Under the present method of computing benefit amounts, benefits for young disability and survivor cases are based on recent and relatively high earnings while benefits for new retirees are based, at least in part, on past earnings levels that were generally much lower than current earnings levels. For a worker with average earnings, the difference in benefit amounts can be substantial—almost $150 a month, and in disability cases may create certain work disincentives. Under wage indexing, the difference would be virtually eliminated.

2. *Base year for indexing*

Your committee's bill would index earnings in retirement cases through the second year before age 62 (the age of first eligibility) rather than to retirement (when the worker is first entitled to benefits). Indexing earnings to first eligibility has significant advantages in the areas of public understanding and administraton.

Since the indexing point is based solely on the date of birth rather than on the year retirement benefits are elected, workers would be assured that their age-62 benefit would not decline should they choose to delay retirement and that it would rise with the Consumer Price Index. If wages were indexed to the date of retirement instead of to age 62, the worker's benefit amount would decline if average wages decline and could be lower than if he had retired earlier, depending on whether price increases out-pace wage increases in the interim. Thus, with retirement indexing, both the worker and his family and Social Security Administration field personnel would be presented with a difficult decision. The worker would have to know how wage and price increases might affect his monthly benefit and would expect SSA personnel to advise him as to the optimum time to retire. Yet neither would have the information necessary to make the correct decision.

Thus, indexing to eligibility, as under the committee bill, would furnish greater certainty for the worker and SSA personnel in advising the worker concerning his decision as to when to retire and apply for benefits.

In addition, age-62 indexing is less complex from an administrative standpoint, and therefore administrative costs would be lower than if earnings were indexed to retirement.

Your committee recognizes that indexing to first eligibility presents some problems. It provides less incentive for a worker to remain in the work force since, all other things being equal, the worker who retires at age 62 and the worker who retires 3 years later at age 65 would receive benefits based on approximately the same PIA. Retirement indexing would provide benefit amounts that are closer to those provided under present law than would occur if earnings were indexed to age 62.

In order to deal with these problems and at the same time retain the advantages of indexing to age 62, your committee has provided for a substantial increase—from one-twelfth of 1 percent per month to three-twelfths of 1 percent per month (from 1 percent to 3 percent per year)—in the delayed retirement credit. Thus, incentives for remaining in the work force would be maintained, and workers' benefits would be increased as a result of work after age 65. (See item B–9 for a discussion of the increase in the delayed retirement credit.)

3. Computation period

Your committee's bill, like present law, provides that benefits will generally be based on a worker's earnings averaged over the number of years after 1950 (or age 21, if later) up to the year the worker reaches age 62, becomes disabled, or dies, whichever occurs first (excluding 5 years of lowest or no earnings). The number of years in the computation period will expand over time—for example, for workers reaching age 65 in 1979, the computation period will be 20 years, and eventually, for workers reaching age 65 in 1994 or later, the computation period will be 35 years.

With the use of actual earnings, as under present law, the expanding computation period depresses replacement rates since early wages, which are generally much lower than current wage levels, must be used in computing the benefits. However, wage indexing would assure that if a worker's earnings increase at the same rate as average wages in the economy, his average indexed monthly earnings (AIME) would rise at the same rate as average wages in the economy.

If the computation period were set at, say, 10 or 20 years, workers with 10 or 20 years of coverage could get the same benefit as workers with 35 or 40 years of service. To avoid such a result, some consideration would probably need to be given to providing for an explicit measure of length of service. However, an explicit provision for measuring continuity of service would pose administrative problems and would tend to raise questions of individual and group equity. Even if there were no administrative problems or questions of equity, a short computation period has the potential for workers to manipulate their earnings late in their careers so that their average earnings are relatively high and, as a result, benefit amounts are relatively high.

Your committee recognizes that, over time, the long computation period tends to distinguish between short- and long-term workers, since, all other things being equal, the latter would have higher average earnings and would, therefore, get higher benefit amounts. Since this method of recognizing length of service seems reasonably adequate and the alternatives present serious problems, your committee is not recommending any change in the computation period.

4. *Benefit formula*

Under present law, benefit amounts for a worker are derived from a table in the social security law and are related to the worker's average monthly earnings in covered employment. The benefit formula that roughly approximates the benefit amounts shown in the present table has 9 steps and, whenever the contribution and benefit base is increased, a new step is added to take account of the higher average earnings possible as a result of the new, higher base. Each time there is an automatic cost-of-living benefit increase, the percentage factors in the formula are increased by the percentage increase in the cost of living.

Under your committee's bill, the benefit formula shown below would be applied to the worker's average indexed monthly earnings (AIME). The formula is designed to produce benefit amounts which are on the average about 5 percent lower than the benefits which would be payable under present law to workers who retire in January 1979, when the revised benefit structure would go into effect:

90 percent of the first $180 of AIME, plus
32 percent of AIME over $180 through AIME of $1,085, plus
15 percent of AIME above $1,085.

This formula would apply to those who reach age 62, become disabled, or die in 1979. The dollar amounts or bend points (the AIME levels at which the weighting in the benefit formula changes) would be adjusted automatically as average wages increase for those who start getting benefits in the future, and the adjusted bend points would be rounded to the nearest multiple of $1.

Indexing both the worker's wages and the bend points in the benefit formula results in maintaining the progressive benefit structure in the future and in the worker's benefit protection rising with general wage levels while he is working.

5. Maximum family benefit

Under present law, the maximum family benefit ranges from 150 percent to 188 percent of the primary insurance amount (PIA).[1]

Your committee recommends retaining the same relationship between maximum family benefits and PIA's as in present law and to accomplish this recommends determining the family maximum by applying the following formula to the worker's PIA:

150 percent of the first $230 of PIA, plus
272 percent of PIA's over $230 through $332, plus
134 percent of PIA's over $332 through $433 plus
175 percent of PIA's above $433.

In the future, the dollar amounts in the formula would be increased based on increases in average wages. This would assure that the current relationship between maximum family benefits and PIA's is maintained.

6. Transition

Your committee's bill would provide a transitional provision to protect the benefit rights of people who are now approaching retirement and whose retirement plans have taken social security benefits into account.

Under your committee's bill, the transitional provision would "guarantee" that a worker (and his dependents or survivors) who first becomes eligible for retirement benefits within 10 years after the effective date would get an initial benefit that would be the higher of:

1. The benefit derived under the new, wage-indexing formula; or
2. The benefit based on the present law benefit as it is in the law on the effective date of the revised system—January 1979.

For purposes of the guarantee, the January 1979 benefit table would not be subject to future automatic benefit increases, but all individual benefits would be subject to all benefit increases becoming effective beginning with age 62. Earnings after age 61 would not be used under the guaranteed benefit computation. With the passage of time, benefits under the wage-indexing system would rise beyond the levels generally payable under the guarantee, since annual wage increases would be reflected in higher AIME and in the adjustments in the benefit formula each year while the guaranteed benefit amounts would remain constant in the future. As a result, the proportion of new retirees that would receive higher benefits under the guarantee would decrease with each passing year.

As shown below, it is estimated that the percent of new retirees eligible for guarantee benefits each year that would receive such benefits would decline from about 43 percent in 1979 to about 2 percent in 1988.

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[1] The amount on which all benefits are based.

Percent of new retirees who become eligible for benefits during transitional period and who would get benefits under guarantee

Year:	Percent
1979	43
1980	33
1981	18
1982	18
1983	8
1984	4
1985	3
1986	2
1987	2
1988	2

The committee's bill would not provide a transition for death and disability cases since benefits in such cases are, under present law, often significantly higher than in retirement cases—a situation which, as discussed in the following section, your committee does not believe should be perpetuated.

7. Disability and death cases

The exclusion of disability and death cases from the transitional guarantee under the bill reflects your committee's concern that benefits in cases where the worker becomes disabled or dies while young may be significantly higher than benefits in retirement cases. This situation occurs because benefits in early disability or death cases are based on earnings averaged over a period as short as 2 years while earnings in retirement cases are averaged over a longer period. For example, benefits for those retiring at age 65 in 1979 will be based on earnings averaged over 20 years. As a result, a younger disabled worker and his family, or the survivors of a worker who died while young, can get higher benefits than the retired worker with the same earnings over the last several years, even though the retired worker worked in covered employment and paid social security taxes over a much longer period. In addition to this problem of the difference in treatment of younger as compared to older workers, your committee is concerned that the high benefits payable in early disability cases can act as a disincentive for disabled workers to return to work or to seek vocational rehabilitation.

Your committee's bill would very substantially reduce—and in some cases eliminate—the higher early disability and death benefit levels that are possible under present law. This effect is due to the fact that wage-indexing brings all earnings up to date, and the length of the computation period becomes less material.

8. Treatment of earnings after age 62 or disability

Under your committee's bill, earnings subsequent to the year of first eligibility (age 62) or onset of disability would be counted at actual dollar value (that is, they would not be indexed) and substituted for earlier years of indexed earnings in the initial computation or recomputation if they would increase a worker's AIME and his PIA. These provisions are similar to those under present law. However, since past earnings would be higher after wage indexing than under present law, earnings after age 62 would, on the average, have substantially less effect in increasing benefit amounts than under present law. Your committee, recognizing that this effect, like the effect of indexing earnings to age 62, may work to reduce incentives for remaining in the labor force, has provided for a substantial increase in the delayed retirement credit (discussed below) in order to increase the incentives for people to continue working past age 65.

Special rules would apply in the case of earnings after age 61 during the transitional period. Workers who are eligible for benefits under the transitional guarantee (because they reach age 62 in the period from 1979 through 1988) could have earnings after age 61 included only under the wage-indexing computation. Earnings after age 61 cannot be included in the computation of guarantee benefits. (Workers age 62 or disabled before 1979 would continue to have their benefits computed and recomputed under the provisions of present law even if they work in covered employment after 1976).)

9. Increase in the delay of retirement credit

Under present law, a person who continues working and delays retirement beyond age 65 gets a delayed retirement credit of one-twelfth of 1 percent of his benefit for each month (1 percent a year) he does not receive a benefit from age 65 and up to the month he reaches age 72.

To provide incentives for workers to remain in the labor force, your committee's bill would provide for an increase in the delayed retirement credit to one-fourth of 1 percent for each month (3 percent per year).

The increased delayed retirement credit would be provided for months after 1981 for workers whose benefits are computed under the new wage-indexed system or under the 10-year transitional guarantee. (Workers whose benefits are computed or recomputed under present law would continue to receive the 1-percent delayed retirement credit.) In 1983, the first year increased benefits reflecting the 3-percent delayed retirement credit would be payable based on credits provided for 1982, 100,000 people would get higher benefits, and $15 million in additional payments would be made as a result of this provision.

10. Treatment of earnings before 1951

Under your committee's bill, earnings before 1951 would not be indexed and could not be used in computing benefits under the new wage-indexing system. Instead, the present-law computation method that applies in the case of pre-1951 earnings would be used; this present-law computation provides for an "empirical" method of allocating pre-1951 earnings. Because earnings in the period 1937–51 are not kept on machine records, the empirical method was devised to simplify the computation of benefits for workers who had earnings before 1951 by eliminating the time-consuming manual computations that would otherwise have to be done. In general, under the empirical method, total earnings in the period from 1937 up to 1951 are allocated equally to each of the years prior to 1951 that are used to determine the worker's average earnings on which his benefit is based. For all practical purposes, the use of pre-1951 earnings in benefit computations would wash out in 1991—when a worker who was age 22 in 1951 reaches age 62. The old start computation is currently used for about 10 percent of new retired worker beneficiaries.

Under your committee's bill the "empirical" computation method provided under present law would continue to be used in the case of pre-1951 earnings. Further, the "empirical" method would be extended to apply to cases involving workers who reach age 21 after 1936[1] and before 1951, since it would represent an administrative simplification. Over the next few years, an increasing proportion of computations using pre-1951 earnings will involve workers age 21 after 1936—people reaching age 62 in 1978 and later attained age 21 after 1936.

11. Freeze the minimum benefit

Your committee's bill provides that the initial minimum PIA of future beneficiaries would be frozen at an amount equal to the minimum PIA in effect in January 1979 (now estimated at about $120.60), rounded up to the next higher dollar. After the worker reaches age 62, becomes disabled, or dies, benefits based on the minimum PIA would be updated to CPI increases, as under present law.

The present minimum age-65 benefit amount is $114.30, and this amount, like other age-65 benefit amounts, is automatically increased for current and future beneficiaries as the cost of living (as measured by the Consumer Price Index) rises. About 3.2 million beneficiaries are receiving benefits based on the minimum, and currently about 10 percent of benefit awards to retired workers are based on the minimum. The minimum benefit of $114.30 is payable on average monthly earnings of $76 or less. It equals 1½ times $76 and about 28½ times the lowest average monthly earnings possible. To many, the minimum benefit represents an identifiable welfare aspect of the social security program.

In the past, the minimum has been increased more rapidly than benefit amounts generally, reflecting the view held widely in the past that people receiving the minimum were among the poorest beneficiaries and were most in need of higher benefits. Over the period 1940–77, the minimum was increased tenfold, while benefit amounts above the minimum have increased about fivefold.

Increasingly, the minimum benefit is being paid to people who did not, during their working years, rely on their covered earnings as a primary source of support. Such people include, for example, workers whose primary work was in noncovered employment subject to a staff retirement system—such as Federal civilian employees. As of December 1975, about 45 percent of civil service retirement annuitants were receiving social security benefits—more than a quarter of whom were receiving the minimum. The median monthly civil service annuity for all those getting social security benefits was about $390, while for those receiving the minimum benefit, it was over $480.

Other people for whom the minimum does not represent a primary source of support include those with marginal labor-force attachment because they were primarily dependent on someone else. (About 46 percent of women entitled to both a benefit on their husbands' earnings and a primary benefit based on their own earnings receive the minimum benefit based on their own earnings.) Less than 25 percent of all workers who first became entitled to the minimum in 1970 had more than 9 years in covered employment since 1950, and slightly more than one-fifth had earned over $1,800 in any year since 1950.

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[1] Under present law the "empirical" formula applies to people who reached age 21 before 1937.

Because of the characteristics of people getting the minimum, it has been characterized as being a "windfall" to people who have not worked regularly under the program. Criticism of the windfall aspect of the minimum has, however, been growing, because the minimum is increasingly going to people who were not primarily dependent on earnings from covered employment.

In general, low-paid workers who worked regularly under the social security program would not be disadvantaged if the minimum were frozen. A regular worker retiring this year with lifetime earnings equal to the prevailing Federal minimum wage each year would get benefits substantially higher than the minimum—$233.50 as compared with $114.30. Even a person who worked regularly at half of the prevailing Federal minimum wage would get more than the minimum—$169.30. Also the special minimum benefit provision for long-term, low-income workers is liberalized by this legislation as noted in the next section of this report.

Freezing the minimum emphasizes that the supplemental security income (SSI) program is an appropriate source of income for needy aged, blind, or disabled people. Those social security beneficiaries who qualify for the relatively lower minimum in the future who are needy could receive SSI to a greater extent at age 65 and after than is true today. The committee believes that this is a more efficient and appropriate method of dealing with the problem of poverty for those who have only a marginal attachment to work covered by social security. Your committee also recognizes that SSI payments are not provided for nondisabled people under age 65 but does not believe that freezing the minimum for people under age 65 would impose an undue hardship. Freezing the minimum would avoid the sharp drop in benefit amounts involved in the elimination of the minimum and would involve similar, though more gradual, reductions in future benefits for people with very low average earnings under social security.

Social security costs would be reduced by about 0.09 percent of taxable payroll over the long range as a result of freezing the minimum benefit amount. Some 150,000 people would receive lower benefits than under present law, and benefit payments would be reduced by $7 million during the first year.

12. Increase in the special minimum benefit

Under your committee's bill, the special minimum benefit, that is provided for long-term, low-paid workers would be (1) increased to take account of price increases since it was last adjusted and (2) kept up to date with future increases in the Consumer Price Index (CPI) for both present and future beneficiaries.

Present law provides a special minimum benefit of up to $180 a month for a worker with 30 years of creditable covered earnings and $270 for a couple. Your committee's bill would increase these benefit amounts to $230 for an individual and $345 for a couple, effective for January 1979, with automatic increases thereafter. The special minimum is calculated by multiplying $9 times the number of years of coverage a worker has in excess of 10 and up to 30—for a maximum multiplier of 20—and under the bill the $9 figure would be increased to $11.50. Generally, a "year of coverage" under present law and your committee's bill is a year in which a person has earnings at least as high as one-quarter of the contribution and benefit base ($4,125 in 1977) in effect for the year and this amount would rise with average wages in the future. In 1979, when the provision takes effect, the special minimum will generally be payable only to low-paid workers with 22 or more years of coverage.

Unlike the regular minimum benefit which, increasingly, may represent a "windfall" for people who did not work regularly under social security, people who get special minimum benefits are ordinarily workers with significant attachment to the covered work force but with very low earnings. The purpose of the special minimum benefit is to provide a reasonably adequate benefit for long-term, low-paid workers under social security without incurring the high costs (and windfalls) that could result from a large increase in the regular minimum benefit or from other possible general benefit adjustments.

The special minimum provision was enacted in 1972, at the same time that the SSI program was enacted, and was designed to help reduce the extent to which long-term, low-paid workers under social security would have to turn to a welfare program to supplement their income. At that time, and in 1973 when the special minimum was last adjusted, there were no provisions for automatic adjustments in SSI payment levels and no provision was made for cost-of-living increases in the special minimum. (Automatic cost-of-living increases in SSI payment standards—currently $177.80 for an individual and $266.70 for a couple—began in 1975.) Since 1973 the number of people drawing benefits based on the special minimum has declined from 217,000 to less than 400 in July 1977.

Your committee believes that if the special minimum is to fulfill its intended purpose, it must be kept up to date in the future. Thus, the bill would provide that the special minimum benefit would be made inflation proof for future beneficiaries by automatically increasing it according to increases in the cost of living. Further, once on the social security rolls, special minimum beneficiaries would receive automatic cost-of-living increases in their specal minimum benefits.

It is estimated that 220,000 people would become eligible for increased benefits under this provision and $14 in additional benefits would be paid in the first full year. Social Security program costs would be increased by about 0.1 percent of taxable payroll over the long range.

C. COVERAGE

Your committee's bill would extend mandatory social security coverage to some 6 million jobs in Federal civilian, State and local, and nonprofit organization employment. As a result, the social security program would cover about 97 percent of all jobs.

The social security program now covers about 90 percent of the jobs in paid employment. The largest group of jobs excluded from social security coverage is about 5.7 million jobs in public employment, most of which are covered under public staff-retirement systems. (About 2.4 million jobs out of 2.7 million jobs in Federal civilian employment are excluded from coverage. Out of 12.3 million jobs in State and local employment, about 3 million jobs are not covered but could be covered if the States elected coverage for these employees and 0.3 million jobs are excluded from coverage.) In addition, some 210,000 jobs in employment for nonprofit organizations are not covered but could be covered if the nonprofit organizations elected to cover their employees. Most of the other jobs not covered represent irregular or part-time work.

Your committee notes that in extending coverage under the bill to Federal and State and local employment, some categories of such employment which are now specifically excluded from coverage by law such as services performed by inmates of Federal and State and local prisons, services performed by temporary, emergency workers, and services by student employees of Federal hospitals would no longer be excluded. Whether coverage should be extended to these specially excepted groups is a complex question which your Commission has not been able to resolve in the time available. However, since under the bill coverage would not be extended to Federal civilian, State and local, and nonprofit organization employment until 1982, your Committee will have time to closely examine the issues and recommend any changes in the coverage extension it believes appropriate.

The following specific coverage groups are added.

1. Federal civilian employees

Your committee's bill would extend social security coverage to the approximately 2.4 million Federal civilian employees now excluded. Most of these employees are covered under the civil service retirement (CSR) system; the remainder are covered largely under other staff retirement systems. The Social Security Act of 1935 excluded from coverage all civilian employment for the Federal Government or for an instrumentality of the United States. At that time, the Federal CSR system, which covered most Federal civilian employment, had been in existence for 15 years and there seemed to be no need for Federal employees to be covered under two retirement systems.

The Social Security Amendments of 1950, as part of a major expansion of the social security program, covered civilian employees of the Federal Government who were not covered under any Federal retirement system. (These employees were short-term Federal employees who were considered likely to shift between Federal and private employment.) The 1950 amendments specifically excluded from coverage services performed for the Federal Government by the President, the Vice President, Members of Congress, legislative employees of the Congress, inmates of Federal penal institutions, certain student employees of Federal hospitals, and temporary, emergency employees.

Your committee has been concerned for many years because the exclusion of most civilian employees of the Federal Government from social security coverage has resulted in two major problems, related mainly to the large number of workers who shift between Federal employment and work covered under social security. The first problem is that there are gaps in protection of workers who have worked both under the CRS system and social security; some employees only qualify for benefits under one system so that their benefits are not based on their lifetime earnings and contributions to both systems, while other employees fail to get benefits under either system. The second problem is that many employees who have worked under both systems are able to qualify for social security benefits by working for relatively short periods in jobs covered under social security, and to also qualify for substantial CSR benefits.

These social security benefits generally are based on substantially less than a full lifetime of covered work and are heavily weighted and represent a very high return on the employee's contributions. This situation is unfair to all workers covered under social security and to their employers, who must bear the cost of the windfall benefits payable to Federal employees.

Over the years many studies of this situation have been made by the executive agencies that have responsibility for administering the social security and CSR systems and various proposals to remedy the situation have been considered. Your committee directed that such studies be made in 1960, 1965, and 1972. None of the proposals advanced has proved acceptable to all concerned. Most recently, the 1975 Advisory Council on Social Security recommended that the social security system be made applicable to virtually all gainful employment and that the Congress should develop immediately ways of achieving this.

Your committee believes that the best way to eliminate the problems that now occur because Federal civilian employment is not covered under social security would be to extend coverage to Federal civilian employees. It is recognized that the complex issue of how the CSR system (and other Federal staff-retirement systems) should be modified to take account of the social security coverage should be resolved before the coverage is made effective. Any modification to the Civil Service Retirement Act will have to be approved by the Committee on Post Office and Civil Service. Thus your committee has delayed the effective date until January 1982.

In addition, the bill provides for a comprehensive study of methods for coordinating the social security system and the civil service retirement system. The study, to be completed not later than January 1, 1980, would be made by the Secretary of Health, Education, and Welfare in consultation with the Civil Service Commission. The Secretary would be directed to present to Congress a specific and detailed plan for the coordination of the two systems. The plan would be expected to provide Federal employees and their families with the best possible combination of retirement, dependents, survivors, disability and health benefits under the two systems at the lowest possible cost consistent with the solvency of the systems. The Secretary is directed to include in the plan benefit provisions and other features to assure that Federal employees would not be placed at a disadvantage either in the coverage protection or in the contributions required of them by the integration of the systems. The date for completion of the study would allow 2 years before the integration takes place for the relevant committees of Congress to act on the plan.

2. State and local employees

Under present law, social security coverage for State and local employees is generally available only on a group basis through voluntary agreements between the States and the Secretary of Health, Education, and Welfare. Coverage for a group of State and local employees can be terminated after 2 years' advance notice by the State if the group has been covered under social security for 5 years at the time notice is given, or by the Secretary at any time if he finds that the State has failed or is unable legally to comply with the terms of the agreement and 2 years' advance notice is given.

Your committee is concerned that, because many State and local employees are not covered currently under social security and those who are covered may have their coverage terminated, inequities in benefit protection have arisen, especially for workers who move between covered and noncovered jobs. In some cases such workers qualify for staff-retirement benefits but do not have enough coverage under social security to qualify for social security benefits and therefore their benefits in retirement do not reflect their lifetime earnings. In other cases such workers qualify for substantial staff-retirement benefits and also for relatively low, heavily weighted (windfall) social security benefits that represent a very high return on the worker's social security contributions. Payment of windfall social security benefits to State and local employees is financially disadvantageous to the social security trust funds and is unfair to other workers, who are covered compulsorily under the social security program.

Your committee is also aware that the provisions in present law not only provide special treatment for State and local employees in general, but also provide special treatment for particular kinds of State and local employees. For example, State and local employees compensated wholly on a fee basis and employees of certain transportation systems acquired by State and political subdivisions from private ownership are covered compulsorily under social security. On the other hand, some State and local employment is excluded from social security coverage: services of employees who are hired to relieve them from unemployment, services in a hospital or other institution by a patient or inmate, and services performed on a temporary basis in the event of an emergency.

Further, certain services performed by employees in a group for which coverage is provided may be excluded at the option of the State: services in elective, part-time, or fee-basis positions and services performed by election workers or officials who are paid less than $50 in a calendar quarter. In addition, a number of provisions which apply only to employees in certain named States, or only to certain employees in a named State, have been enacted from time to time. Your committee believes that provisions for special treatment for certain State and local employees are unfair to other State and local employees and complicate administration of the social security program.

The 1975 Advisory Council on Social Security studied major areas of employment not covered under social security (including State and local employment) and urged that these areas be covered compulsorily. Also, in April 1976 your committee held hearings to explore the issues relating to the social security coverage and termination of coverage of employees of State and local governments. During the hearings a number of approaches to solving the problems that arise under the present State and local coverage provisions were discussed; compulsory coverage is the most satisfactory approach to those problems.

Compulsory coverage of State and local employment would fill the gaps in protection of those who move between noncovered State and local employment and work covered under social security. Contributions and benefits provided under staff-retirement systems for groups not now covered under social security could be adjusted to take account of social security coverage and contributions. Coordinated coverage under social security and a staff-retirement system would assure that benefits under both systems would be reasonably related to a worker's lifetime earnings and contributions.

Some have argued that under recent opinions of the Supreme Court it would be unconstitutional to provide for mandatory taxation of the States and localities as employers. However, recent decisions have been limited to the commerce power and there is no controlling opinion on the exercise of the general welfare and taxation power. Your committee believes that there is a compelling national interest in universal coverage linked to the solvency of the social security system which is sufficient to sustain this legislation.

Your committee's bill would provide compulsory social security coverage effective January 1, 1982, for all State and local employees (including employees of Guam, American Samoa, and the District of Columbia) who are not covered compulsorily under present law.

The bill would also provide that coverage could not be terminated for a group of State and local employees unless the required 2 years' advance notice was filed before September 14, 1977. This would prevent terminations after September 1979; State and local employees whose coverage had been terminated would also be covered effective January 1, 1982.

Your committee bill also contains a number of provisions affecting coverage for State and local employees in particular States.

3. Employees of nonprofit organizations

Under present law, work performed for nonprofit religious, charitable, educational, or other tax-exempt organizations specified in section 501(c)(3) of the Internal Revenue Code is excluded from compulsory coverage under the Social Security Act. The exclusion was enacted because it was believed that taxation of the organizations under the Federal Insurance Contributions Act would endanger the traditional tax-exempt status of the organizations. Work performed for other nonprofit organizations, listed in section 501(c) of the Code, is covered compulsorily.

Social security coverage is available to employees of an organization described in section 501(c)(3) of the Code if the organization files with the Internal Revenue Service a certificate expressing its desire to have the coverage extended to its employees. Current employees of such an organization have a choice of whether or not they want to be covered under social security; future employees of such an organization are covered compulsorily. Under the present provisions, 90 percent of all employees of these organizations are covered under social security. Under the bill, work performed for an organization specified in section 501(c)(3) of the Code would be covered compulsorily under social security beginning January 1, 1982.

Your committee believes that the basis used in the past for excluding these nonprofit organizations from social security taxation is no longer valid and that compulsory coverage under social security would solve the problems, such as those discussed earlier with respect to State and local coverage, that result because some employees are not covered currently under social security and those who are covered may have their coverage terminated. Compulsory coverage would prevent gaps in the protection of employees who have divided their working lifetimes between covered and noncovered employment, and would prevent employees whose major employment is not covered or is terminated from qualifying for windfall social security benefits by working for relatively short periods in covered jobs. Also, some organizations have reported their employees' wages for social security purposes and have paid social security taxes without filing the required certificate. Such organizations have filed for refunds of the erroneously paid taxes, and some employees who were relying on the social security protection were no longer covered. Although Public Law 94–563, enacted October 19, 1976, was designed to prevent the loss of social security coverage in these situations, compulsory coverage would eliminate the complex provisions and problems that now apply.

Under present law, an organization which filed a certificate can terminate coverage of its employees by giving 2 years' advance notice of the termination provided coverage has been in effect for at least 8 years. Also, the coverage can be terminated by the Secretary of the Treasury, with concurrence of the Secretary of Health, Education, and Welfare, at any time if he finds that an organization has failed to or is unable to comply with the law and 60 days' notice of the termination is given. Under the bill, no termination would be allowed before compulsory coverage was effective unless the notice to terminate was given on or before September 13, 1977. The bar to future terminations would prohibit nonprofit organizations from terminating social security coverage of their employees in order to avoid paying social security taxes for a period before compulsory coverage was effective.

4. Quarter-of-coverage provision for Federal, State and local service, and service for nonprofit organizations performed prior to effective date of coverage

Your committee is concerned over possible disadvantages arising out of the late entry into social security coverage of Federal civilian and State and local employees and employees of nonprofit organizations. If no special provision is made for these employees, many who retire, become disabled, or die within a few years of the time social security coverage is extended will not have worked long enough to qualify for social security benefits for themselves or their families even though they (and their employers) may have paid substantial social security contributions. Under social security law, in order to be insured for retirement and survivors benefits, an individual generally needs as many quarters of coverage (but no more than 40) as the number of years elapsing after 1950 (or age 21, if later) and up to the year of attainment of age 62 or death. In addition, a person is insured for survivors benefits if he has at least 6 quarters of coverage in the 13-quarter period ending with the quarter in which he died. In order to qualify for social security disability benefits, an individual needs as many quarters of coverage as the number of years elapsing after 1950 (or age 21, if later) and up to the year he becomes disabled. In addition, if he becomes disabled at age 31 or older he must have 20 quarters of coverage (5 years) in the 40-quarter period ending with the quarter in which he becomes disabled. Thus, for example, a Federal civilian employee who was 57 years old in 1982, when social security coverage became effective, and who retired in 1985 at age 60, would have earned at most 16 quarters of coverage from his Federal employment—not enough to qualify for social security disability or retirement benefits.

In recognition of this problem, your committee's bill would provide that any employee in covered Federal, State and local, or nonprofit employment on or after January 1, 1982 (who also performed service as an employee in such employment before 1982), would be granted credits for quarters of coverage, but not for earnings for benefit computation purposes, with respect to such employment before 1982, provided the employee earned at least 6 quarters of coverage from such employment after December 31, 1981.

5. Totalization Agreements

Under present law, there is no authority in the Social Security Act for entering into agreements with other countries to provide for coordination between the social security systems of the United States and of other countries. Your committee is concerned that because there is no coordination between the U.S. social security system and foreign social security systems, two serious problems occur.

First, the work of many U.S. citizens employed by U.S. employers in foreign countries is subject to the social security taxes of the United States and is also subject to the social security taxes of the foreign country. Not only are the tax payments to foreign systems generally higher than in the United States but frequently American workers get little if any, return for the taxes they and their employers pay to the foreign systems because social security eligibility requirements are usually stricter under foreign systems.

Second, many U.S. citizens who divide their working careers between work covered under the U.S. social security system and work covered under a foreign social security system suffer a loss of continuity in their social security coverage. Some who work abroad for a number of years and have periods of coverage under two or more social security systems may not qualify for benefits under one or more countries when they retire, become disabled, or die. (For example, American workers who work abroad for a number of years may lose their U.S. security disability protection because to be insured for disability benefits they must generally have substantial recent covered work covered by the U.S. system.) Others may qualify for social security benefits but the social security benefits they receive are not related to their work lifetimes since not all their credits can be taken into account.

Your committee's bill would help solve these problems by authorizing the President to enter into bilateral agreements (of a kind generally known as totalization agreements) with foreign countries to provide for limited coordination between this country's social security system and those of other countries. Each agreement would be submitted to the Congress and could not go into effect until 90 days (in which the Congress has been in session) after the agreement had been submitted.

A totalization agreement would eliminate dual coverage and dual employee and employer social security taxes for the same work. An agreement could also provide that each country would take into account a worker's total work and earnings in both countries for purposes of determining eligibility for and the amount of benefits. Each country would pay only a part of the totalized benefit; the amount of the benefits paid would be the proportion of the totalized benefit which is attributable to the covered work performed in the paying country. The United States would not pay a totalized benefit to a worker who had less than 6 quarters of coverage under the U.S. system. While totalization would improve protection for people who worked in both countries, in a large proportion of cases of the worker is insured based on his U.S. work alone, his regular social security benefits would be higher than his totalized benefit.

Totalization agreements (which are common among European countries) have an advantage over other approaches to coordination in that the agreements are designed to allow each cooperating country to carry out its responsibilities virtually independently. The countries would exchange information on covered earnings and earnings credits and provide other administrative assistance, but otherwise each country would make its determinations and computations independently and would pay benefits directly, without any need for an interchange of funds or balancing of amounts paid as benefits.

A number of countries, including Italy, West Germany, Switzerland, Canada, France, and Japan, have approached the United States about the possibility of concluding social security totalization agreements, and the Social Security Administration has had technical discussions with representatives of each of these countries except Japan. A draft totalization agreement between the United States and Italy was signed in 1973 and a draft totalization agreement between the United States and West Germany was signed in 1976, to signify only that the countries accepted the text of the agreement for purposes of seeking the approval of their national legislatures. Both Italy and Germany have enacted the agreement with the United States into their laws. The agreements cannot become effective until they are authorized for the United States as provided in the bill. Thus, the agreements with Italy and West Germany would have to be submitted to the Congress after enactment and await the 90 day review period before they could become effective.

6. *Exclusion of limited partnership income*

Under present law each partner's share of partnership income is includable in his net earnings from self-employment for social security purposes, irrespective of the nature of his membership in the partnership. Under the bill the distributive share of income or loss received by a limited partner from the trade or business of a limited partnership would be excluded from social security coverage. However, the exclusion from coverage would not extend to guaranteed payments (as described in section 707(c) of the Internal Revenue Code), such as salary and professional fees, received for services actually performed by the limited partner for the partnership. Distributive shares received as a general partner would continue to be covered. Also, if a person is both a limited partner and a general partner in the same partnership, the distributive share received as a general partner would continue to be covered under present law.

Your committee has become increasingly concerned about situations in which certain business organizations solicit investments in limited partnerships as a means for an investor to become insured for social security benefits. In these situations the investor in the limited partnership performs no services for the partnership and the social security coverage which results is, in fact, based on income from an investment. This situation is of course inconsistent with the basic principle of the social security program that benefits are designed to partially replace lost earnings from work.

These advertisements and solicitations are directed mainly toward public employees whose employment is covered by public retirement systems and not by social security. Also, these advertisements frequently emphasize the point that those who invest an amount sufficient to realize an annual net income of $400 or more (the minimum amount needed to receive social security credit in a year) will eventually gain a high return on their social security contributions. Many of those who invest in limited partnerships will qualify for minimum benefits, which are heavily weighted for the purpose of giving added protection for people who have worked under social security for many years with low earnings. The cost of paying these heavily weighted benefits to limited partners must, of course, be borne by all persons covered by the social security program. The advertising injures the social security program in the public view and causes resentment on the part of the vast majority of workers whose employment is compulsorily covered under social security, as well as those people without work income who would like to be able to become insured under the social security program but cannot afford to invest in limited partnerships.

7. *Social security employer taxes on tips when deemed as wages for the Federal minimum wage*

Under the Fair Labor Standards Act of 1938, an employer can pay an employee less than the Federal minimum wage by an amount equal to the tips received by the employee but not by more than 50 percent of the minimum wage. Since employers are exempt from paying the employers' share of social security taxes on tips received by their employees, employers do not pay this tax on the amounts of tips deemed to be wages for purposes of the Federal minimum wage. Under the bill, liability for the employers' share of social security taxes would be extended to any tips deemed to be wages under the Fair Labor Standards Act. Your committee believes that these employers should not receive an advantage over other employers whose employees do not receive tips, and who must pay the employers' share of the social security tax on the full amount of the minimum wage.

8. *Clergymen*

Under present law, the services which a clergyman (including a Christian Science practitioner) or member of a religious order who has not taken a vow of poverty[)] performs in the exercise of his ministry are covered as self-employment for social security purposes beginning with 1968 unless he obtains an exemption from social security taxes (and coverage) by filing within a prescribed period (under section 1402(e) of the Internal Revenue Code of 1954) an application for exemption, together with a statement that he is conscientiously opposed to the acceptance (with respect to his services as a clergyman) of any public insurance such as social security. Any exemption received under present law is irrevocable.

Your committee's bill would permit a clergyman to revoke his exemption if application for such revocation was filed before he became entitled to social security retirement or disabilty benefits and no later than the due date of a Federal income tax return for his first taxable year beginning after the date of enactment of this bill. However, once revocation was made, he could not again file an application for exemption. Social security coverage for a clergyman who revoked his exemption would begin with his first taxable year ending on or after enactment or beginning after enactment (whichever is specified in the application) and would be effective for social security benefits payable for months in or after the calendar year in which the application is filed.

9. Other State and local changes

a. Validation of coverage for policemen and firemen in Illinois

Under present law, social security coverage is available, in certain jurisdictions specifically named in the law, to policemen and firemen who are in positions covered under a State or local retirement system on much the same basis as to other State and local government employees who are covered under retirement systems.

In the States not named in the law, policemen in positions under a retirement system cannot be covered. However, firemen in these States who are under a retirement system can be covered if special conditions in the Federal law are met. The Governor of the State must certify that the overall benefit protection of the group of firemen would be improved by extension of social security to the group; the coverage can then be extended by means of a referendum in which only firemen may vote.

Illinois is not one of the States listed in the law in which social security coverage may be extended to policemen and firemen who are in positions under a retirement system, nor has it taken the required action to cover firemen in such positions. However, for a number of years, Illinois has been reporting as covered under social security the earnings of some policemen and firemen who are covered under the Illinois Municipal Retirement Fund (IMRF).

Your committee's bill would deem services performed prior to December 31, 1977, by policemen and firemen in Illinois covered under the IMRF to be covered under social security if social security contributions had been timely paid with respect to the services and either there has been no refund of the contributions or such refund is repaid within 90 days of enactment. The erroneous coverage would not be validated for the services of policemen and firemen employed by a political subdivision which indicated that it did not wish such coverage to be validated.

b. Coverage of policemen and firemen in Mississippi

The bill would make applicable to the State of Mississippi the provision in the Social Security Act which makes social security coverage available, in certain jurisdictions specifically named in the law, to policemen and firemen who are in positions covered under a State or local retirement system, on much the same basis as to other persons under retirement systems. Under present law, the provision applies to 21 States, Puerto Rico, and to all interstate instrumentalities.

In Mississippi, and in other States not named in the law, social security coverage is not available to policemen who are in positions covered under a State or local retirement system. It is available for firemen under a retirement system in these States, but only if special conditions set forth in the Federal law are met. The Governor of the State must certify that the overall benefit protection of the group of firemen which would be brought under coverage would be improved by reason of the extension of coverage to the group, and coverage can be extended only by means of a referendum in which only firemen may vote. Your committee's bill would add Mississippi to the list of States which may make social security coverage available to policemen and firemen who are covered under a State or local retirement system.

c. *Coverage of State and Local Employees in New Jersey Under the Divided Retirement System Procedure*

The bill would make applicable to the State of New Jersey the provision in the Social Security Act which makes social security coverage available, in certain jurisdictions specifically named in the law, under the divided retirement system procedure. Under present law, social security coverage for employees of the States and their political subdivisions is available only through agreements between the Secretary of Health, Education, and Welfare and the individual States. Each State decides what groups of eligible employees will be covered, subject to provisions in the Federal law which assure retirement system members a voice in any decision to cover them under social security. Federal law provides two methods for covering members of State and local government retirement systems. Under the first method, the referendum procedure which is available to all States, coverage is extended to all present and future employees who are in positions under a retirement system if a majority of the eligible employees approve such coverage in a referendum vote.

Under the other method, the "divided retirement system" procedure, which is now applicable to 20 States specifically listed in the law and all interstate instrumentalities, coverage may be extended to only those present employees in positions under a retirement system who desire it, with all employees who subsequently enter or reenter positions under the retirement system being coverage automatically. Your committee's bill would add New Jersey to the list of States which may use the divided retirement system procedure.

Even though your committee is extending mandatory coverage to State and local employees in the future, this provision has been included in the bill to make it possible for those employees in New Jersey who wish to come in to the system to do so at an earlier time.

d. *Coverage of employees under Wisconsin retirement system*

Social security coverage for employees of the States and their political subdivisions in positions not under a retirement system was made available by legislation enacted in 1950 through agreements entered into between the Secretary of Health, Education, and Welfare and the individual States. In 1953, the Social Security Act was amended to provide that the agreement with the State of Wisconsin could be modified to apply to service performed by all employees in positions covered by the Wisconsin Retirement Fund.

Subsequent amendments to the Social Security Act enabled all States to provide coverage for employees of a State or political subdivision in positions under a retirement system, by either of two methods. Under one method, applicable to all States, coverage is extended to all present and future members of a retirement system if a majority of the eligible employees approve such coverage in a referendum vote. Under the other method, which is applicable to certain specified States, including Wisconsin, coverage may be extended to only those current members of a retirement system who desire it, with all future members of the retirement system being covered compulsorily.

The State of Wisconsin, using the exception enacted in 1953, provided coverage for employees in all positions under the Wisconsin Retirement Fund but utilized the special referendum procedure in providing coverage for the Milwaukee Teachers Retirement System and the State Teachers Retirement System. The State now proposes to merge the three retirement systems; the successor system would be known as the Wisconsin Retirement System.

Your committee's bill would provide that the special provision of the Social Security Act that pertains to the Wisconsin Retirement Fund would apply to any successor of that Fund. This change would assure continued social security protection for members of the Wisconsin Retirement System, that future members of the System would be covered under social security, and that a referendum would not be necessary each time a new group becomes a participant in the System.

D. EQUAL TREATMENT OF MEN AND WOMEN

1. *Equal rights*

The social security law contains a number of relatively minor provisions that are different for men and women. Your committee believes that these provisions should be changed to eliminate the gender-based distinctions and terminology and provide the same rights for men and women. To accomplish this it has included in its bill the following provisions, most of which have negligible costs. With the exceptions indicated below, these provisions would be effective with respect to benefits for months after December 1977.

a. Father's benefits

Benefits are provided by the present statute for a woman who has in her care a minor or disabled child (entitled to child's benefits) of her retired, disabled, or deceased husband, or deceased former husband. By virtue of a 1975 Supreme Court decision in *Weinberger* v. *Wiesenfeld* benefits are also provided for a similarly situated widowed father. (In *Wiesenfeld*, the Court ruled that benefits must be provided for a widower with an entitled child in his care on the same basis as they are provided for a widow with an entitled child in her care.) Also under the law, benefits are not provided for a father who has in his care an entitled child of his retired or disabled wife or deceased former wife.

Your committee's bill would provide benefits for men who were not covered by the Supreme Court decision—young husbands of retired or disabled workers, and surviving divorced husbands with an entitled minor or disabled child of the retired, disabled, or deceased worker in their care. The bill would also change the statute to reflect the Supreme Court decision in *Weinberger* v. *Wiesenfeld.*

It is estimated that 2,000 husbands or surviving divorced husbands would become newly eligible for benefits or eligible for larger benefits on the effective date. An estimated $2 million in additional benefits would be paid in the first full year of operation.

b. Benefits for divorced men

Present law provides benefits based on a former spouse's social security earnings record for an aged divorced wife and an aged or disabled surviving divorced wife but not for divorced men in like circumstances. The committee bill would provide such benefits for aged divorced husbands and aged or disabled surviving divorced husbands.

It is estimated that 2,000 people would become newly eligible for benefits or eligible for larger benefits on the effective date. An estimated $3 million in additional benefits would be paid in the first full year of operation.

c. Remarriage of widowers before age 60

Present law provides that an aged or disabled widow (or surviving divorced wife) may qualify for widow's benefits if she "is not married" when she applies for benefits. For a widower (or surviving divorced husband), on the other hand, the requirement specifies that he may qualify for widower's benefits if he "has not remarried." As a result of this difference, a widower (or surviving divorced husband) cannot ever become entitled to widower's benefits based on his deceased wife's (or deceased former wife's) earnings if he has remarried before age 60, even if he is not married at age 60.

The committee bill would permit a widower (or surviving divorced husband) to obtain benefits based on his deceased wife's (or deceased former wife's) social security if he is not married at the time he applies for widower's benefits, as widows now can. This provision would be effective after December 1977. However, this provision will be superceded when another provision in your committee's bill to eliminate marriage or remarriage as a factor in terminating or reducing benefits becomes effective in 1979.

d. Transitional insured status

A 1965 amendment to the social security law made certain people who attained age 72 before 1969 eligible for benefits based on a shorter time in covered employment than would otherwise be required. Benefits were also provided for certain wives and widows who attained age 72 before 1969, but similar benefits were not provided for husbands or widowers.

Your committee's bill would provide such benefits for husbands and widowers under the same conditions as for wives and widows.

e. Benefits at age 72 for certain uninsured individuals

An amendment to the social security law enacted in 1966 made it possible for certain people who reach age 72 before 1968 to get special monthly cash payments (financed from general revenues) even though they have not worked in jobs covered by social security. The special payments can also be made to people who reach age 72 after 1967 and before 1972 if they have a specified amount of work under social security but not enough to qualify for regular retirement benefits.

When both members of a couple are receiving such payments, the husband receives a full benefit (now $78.50) and the wife gets a benefit equal to one-half the husband's benefit (now $39.30).

The committee bill would provide that when both members of a couple are receiving special age-72 payments, the total amount of the payments ($117.80) to the couple would be divided equally between the two.

f. Benefits of spouses of childhood disability or disabled worker beneficiaries

When a childhood disability beneficiary (a retired, disabled, or deceased worker's child who has been disabled since before age 22) marries another person getting dependent's or survivor's benefits, and when a disabled worker marries a childhood disability beneficiary or a mother, surviving divorced mother, or father, neither's benefits are terminated by reason of the marriage. Subsequent treatment of the spouse's benefits if the childhood disability beneficiary or disabled worker beneficiary has medically recovered or engages in substantial work and has his or her disability benefits terminated varies depending on the sex of the disability beneficiary. If the disability beneficiary is a male, the benefits of his spouse end when his benefits end. If, on the other hand, the disability beneficiary is a female, the benefits of her spouse do not end when her benefits end.

Your committee has approved a change in the law under which this disparity in the rights of men and women would be removed. Specifically, the committee approved bill provides that the benefits of the spouse of a female disability beneficiary would be terminated if she ceases to be disabled, as is now the case if the disability beneficiary is a male. The termination of benefits of the spouse of the disability beneficiary would be consistent with the treatment under present law accorded other dependent and survivor beneficiaries who remarry. However, under the provisions of the committee bill to eliminate marriage or remarriage as a factor in terminating or reducing benefits, which will take effect later than the equal rights provisions of the bill, spouses of disability beneficiaries whose benefits are terminated under this equal rights provision of the bill will be able to become reentitled to benefits.

g. Benefit rights of illegitimate children

Present law provides that a man's illegitimate child who cannot inherit from him under applicable State law relative to devolution of intestate personal property may nevertheless be deemed to be his child for purposes of receiving social security benefits under certain conditions. Certain of these provisions may also apply with respect to such a child of a woman, but certain others do not.

Since the child may become entitled to benefits on his mother's social securiy record under other provisions of the law, the lack of exactly the same provisions in the case of mothers has not resulted in a denial of benefits for the child.

Nevertheless, your committee believes that the law should be changed to avoid such a gender-based distinction. Accordingly, the committee bill would provide that an illegitimate child's status for purposes of entitlement to child's insurance benefits will be determined with respect to the child's mother in the same way as it is now determined with respect to the child's father.

In addition, the committee bill would change the social security statute with respect to children of disabled workers to conform to a 1974 Supreme Court decision in *Jimenez* v. *Weinberger*. That decision provided that certain illegitimate children could get benefits based on a worker's earnings if the relationship and/or living with or support requirements in the law are met at the time the child applies for benefits instead of before the worker becomes disabled, as the statute provides. The committee bill makes a similar change with respect to children of retired workers.

h. Waiver of civil service survivors annuities

Generally, present law provides that if a civil service annuity based in part of military service performed before 1957 is payable to an individual, such service may not be used in determining eligibility for or the amount of such individual's social security benefit. An exception applies to a widow (or child), but not a widower, entitled to a civil service survivor's annuity based in whole or in part on pre-1957 military service. The widow (or child), but not a widower, may waive the right to the civil service survivor's annuity and receive credit for pre-1957 military service for purposes of determining eligibility for or the amount of social security survivor's benefits.

The committee believes that a widower, as well as a widow, should be permitted to waive payment of a civil service annuity attributable to credit for military service performed before 1957 in order to have the military service credited toward eligibility for or the amount of a social security benefit, and has made provision for such in the bill.

i. Crediting of self-employment income in community property States

Present law provides that all income from self-employment in a trade or business owned or operated by a married couple in a State in which community property statutes are in effect be deemed to be the husband's for social security purposes unless the wife exercises substantially all the management and control of the business, in which case all the self-employment income is treated as the wife's. In noncommunity property States, self-employment income of married couples is credited to the spouse who owns or is predominantly active in the business.

The committee bill would permit self-employment income of a married couple in a community property State to be credited for social security purposes to the spouse who exercises more management and control over the trade or business, with respect to taxable years after 1977. Where the husband and wife exercised the same amount of management and control the self-employment income would be divided equally between both the husband and wife.

2. Elimination of marriage or remarriage as a factor terminating or reducing benefits of certain beneficiaries

Present law provides, in general, that the marriage (or remarriage) of a worker's divorced or surviving spouse, parent, or child prevents or terminates entitlement to benefits based on the worker's social security earnings record. For example, a widow who remarries before age 60 cannot get benefits based on her first husband's earnings as long as she is married. If she remarries after age 60, the benefits based on the first husband's social security are reduced or terminated; the widow gets either a wife's benefit based on her first husband's earnings (which is less than the widow's benefit she was getting) or a wife's benefit based on her current husband's earnings (if he is a beneficiary), whichever is higher. Benefits are not payable to divorced spouses and young surviving spouses who are remarried.

Your committee is especially concerned about the effect of these provisions on older surviving spouses (and divorced spouses). Accordingly, your committee has recommended changes in the law which would eliminate marriage or remarriage as a factor affecting entitlement to benefits or benefit amounts. Specifically, under your committee's bill, marriage or remarriage would not bar or terminate entitlement to benefits as a divorced spouse, surviving spouse (including those with an entitled child in their care), parent, or child, and remarriage would not cause any reduction in aged widow's or widower's insurance benefits. Also, the dependent's benefits of a person married to a disabled worker or an adult disabled since childhood would no sions of present law. An estimated $1.4 billion in additional benefits would be paid in the first full calendar year 1980.

The amendments made by your committee would apply with respect to benefits for months after December 1978. People whose dependents' benefits were terminated because of marriage or remarriage (or because of the recovery of a previously disabled spouse) prior to January 1979 may again become entitled to such benefits thereafter upon application for reentitlement.

In the first full year of operation an estimated 670,000 people would be eligible for benefits that they would not get because of the provisions of present law. An estimated $1.3 billion in additional benefits would be paid in the first full year.

3. Duration-of-marriage requirement for divorced women (and men)

In 1965, the Congress provided benefits for aged divorced wives and aged surviving divorced wives of retired, disabled, or deceased insured workers, subject to a 20-year duration-of-marriage requirement. In providing these benefits, your committee stated that the purpose of doing so was to:

> . . . provide protection mainly for women who have spent their lives in marriages that are dissolved when they are far along in years—especially housewives who have not been able to work and earn social security benefit protection of their own—from loss of benefit rights through divorce.

Generally speaking, with a period of marriage considerably shorter than 20 years there is a greater likelihood that a divorced person will either qualify for benefits as a spouse in a second marriage or have earnings and qualify for benefits as a worker under social security. Your committee is concerned, however, that older divorced people married less than 20 years may nevertheless reach old age without any social security protection. Accordingly, your committee's bill would reduce from 20 years to 5 years the length of time a person must have been married to a worker in order for benefits to be payable to an aged divorced spouse or surviving divorced spouse.

The amendment would be effective with respect to benefits for months after December 1978.

It is estimated that 70,000 people would become newly eligible for benefits or eligible for larger benefits on the effective date. An estimated $160 million in additional benefits would be paid in the first full calendar year, 1980.

4. *Study of proposals to eliminate dependency and sex discrimination*

As discussed previously, your committee's bill contains amendments which would make a number of relatively minor social security provisions the same for men and women. However, there are a number of more broad-scale proposals for changing the social security program to take into account the changing role of women in society. Your committee is concerned that the social security program provide adequate protection in terms of the needs of today's society and that women, as well as men, be treated equitably under the program.

Therefore, your committee has directed the Secretary of Health, Education, and Welfare, in consultation with the Task Force on Sex Discrimination in the Department of Justice, to carry out a detailed study of proposals: (1) to eliminate dependency as a requirement for entitlement to social security spouse's benefits, and (2) to bring about the equal treatment of men and women in any and all respects. In conducting this study the Secretary shall take into account the effects of the changing role of women in today's society including such things as: (1) changes in the nature and extent of women's participation in the labor force, (2) the increasing divorce rate, and (3) the economic value of women's work in the home. The study shall include appropriate cost analyses. A full and complete report shall be submitted by the Secretary to the Congress within 6 months after enactment of the bill.

E. IMPROVEMENTS OF THE EARNINGS TEST

The earnings limitation or retirement test for social security beneficiaries continues to bother many Americans who believe that retirees should be encouraged to work rather than discouraged from working. Your committee has provided what it believes is the most liberal amendment possible, consistent with the fiscal condition of the old-age and survivors insurance system.

1. *Annual exempt amount.*—Under present law, if a beneficiary under age 72 earns more than the annual exempt amount ($3,000 in 1977; more in subsequent years) in a year, $1 less in benefits is paid for each $2 of earnings in excess of the $3,000. However, full benefits are paid, regardless of the amount of annual earnings, for any month in which the beneficiary neither works for wages in excess of the monthly measure ($250 in 1977; more in later years) nor renders substantial services in self-employment. Under the bill, beginning in 1978, the annual exempt amount would be increased so that a beneficiary age 65 or over (but under age 72) would receive the full amount of his benefits each month if his annual earnings did not exceed $4,000, and beginning in 1979, such a beneficiary would receive the full amount of his benefits each month if his annual earnings did not exceed $4,500. Bene-

ficiaries under age 65 would continue to be subject to the annual exempt amount provided under present law. The provisions for the automatic adjustment of the annual exempt amount under present law would not be effective for beneficiaries age 65 or over (but under 72) for either 1978 or 1979.

2. *Monthly earnings test.*—The bill would change the retirement test so as to eliminate, for years after the initial year of retirement, the provision under present law that allows a beneficiary to receive full benefits for any month in which the beneficiary neither works for wages of more than the monthly measure nor renders substantial services in self-employment.

The present test, with a combined annual-monthly measure of earnings, creates an anomaly by permitting the payment of benefits in some situations where payment is difficult to justify. For example, a beneficiary who earns, say, $20,000 a year and who works regularly throughout the year has all benefits withheld. A beneficiary who earns the same amount, but works only part of the year, say 8 months, can receive benefits for the remaining 4 months. Also, people who customarily work less than a full 12 months each year (for example, in seasonal employment) can, upon reaching the age of eligibility for benefits, receive some social security benefits during the year even though their work patterns have not changed and their annual earnings are substantial.

Your committee's bill would provide that the monthly measure would apply only in the initial year of retirement. This provision would assure that a beneficiary who retires after earning a substantial amount in the year of retirement would get benefits for the months in that year in which the beneficiary actually was retired.

3. *Foreign work test.*—The regular earnings-related retirement test is not a practical test for beneficiaries who work outside the United States in employment that is not covered by social security, primarily because of the wide variations in earnings levels in the many countries in which U.S. social security benefits are payable, the changing values of foreign currencies, and the administrative difficulties that a monthly earnings test would present in dealing with beneficiaries living abroad. For these beneficiaries, benefits are payable in full for any month in which a beneficiary works 6 or fewer calendar days, regardless of how many hours he works in these days and regardless of how much money he earns; he receives no benefits for any month in which he works in 7 or more calendar days.

Unless your committee's bill, benefits would not be payable for any month in which a beneficiary worked in 9 or more calendar days in 1978 and in 12 or more calendar days in 1979. Liberalization of the foreign work test is meant to allow beneficiaries who work outside the United States an increase in their earnings without losing benefits, just as the increased amount of the annual exempt amount for the regular retirement test allows beneficiaries in the United States to earn more without suffering deductions from their benefits.

F. ANNUAL WAGE REPORTING

Public Law 94–202, enacted January 2, 1976, made changes in the law to institute a single annual wage reporting system under which forms W–2 will be used as the annual reports of wages for both social security and income tax purposes effective with reports of wages paid in 1978. Annual reporting will eliminate the quarterly reporting of a detailed listing of wages paid to each employee covered under social security. Employers will still have to file with the Internal Revenue Service quarterly reports which contain summary wage and tax liability information. State and local employment is excluded from the change to annual reporting.

The annual reporting provisions of Public Law 94–202 made no changes in the provisions of the Social Security Act which deal with the crediting of covered work on a quarterly basis. As a result, employers will have to include on forms W–2 data on wages paid the worker in each quarter so that the Social Security Administration can determine whether a worker has enough quarters of coverage to be eligible for benefits. Thus, the annual reporting provisions of present law do not provide the optimum advantages for employers or for the Government that annual reporting was intended to achieve because quarterly wage data will still need to be reported by employers and the data will have to be processed by the Social Security Administration.

Your committee's bill would change the provisions of the social security law which refer to, or are based on, the use of quarterly wage data, so that only annual data would be reported on the forms W–2. Under the bill, annual wage data would be substituted for quarterly wage data for automatically adjusting the contribution and benefit base and the retirement test exempt amount, as well as in computing the benefit reduction when a worker is entitled to workmen's compensation, in applying coverage tests to certain jobs, and in granting military service noncontributory wage credits.

The most significant program change would be a provision setting out how annual wages would be credited in terms of quarters of coverage. Under present law, a worker generally receives credit for a quarter of coverage for a calendar quarter in which he received at least $50 in wages. Under the bill, a worker would receive one quarter of coverage (up to a total of four) for each $250 of earnings in a quarter, and the $250 measure would be increased automatically every year to take account of increases in average wages.

Your committee believes that because wage levels have advanced so tremendously since the $50 measure was established in 1939, raising the measure to $250 in this context would not make it more difficult for workers in general to secure social security credits. While there would be relatively few workers who would lose some quarters of coverage, over a working lifetime most would become insured anyway. On the other hand, some workers would get some additional quarters of coverage, but again most would have become insured anyway. The quarter-of-coverage measure was set at $250, with annual automatic adjustments, in order to avoid significant increases in program costs.

G. OTHER PROVISIONS

1. *Limit cost of living increases for early retirees*

Your committee's bill would change the method of increasing reduced benefits after the initial month of entitlement. If an individual elects to receive social security benefits before reaching age 65, the benefits are reduced to take into account, in general, the longer period for which benefits are to be received. Currently, benefits are reduced for the number of months from first entitlement to age 65. However, if benefits are subsequently increased, the increase is reduced for the number of months from the month of increase to age 65.

After age 65 there is no reduction in the increase. Thus, a person who started gettting retirement benefits at age 62 (with a 20 percent actuarial reduction) gets benefit increases without reduction after age 65. In such cases, the cost-of-living increase in the individual's benefits will exceed the percentage increase necessary to maintain the purchasing power of his original reduced benefit amount.

Under your committee's bill subsequent benefit increases would be subject to the same reduction factor as that which was initially applied—from the month of initial entitlement to retirement age. As under current law, the reduction factor would be adjusted at age 65 (and also at age 62 for widows and widowers) to take account of prior months for which benefits were not payable. (Your committee's bill also contains a provision to prevent deliberalization of benefits of individuals already receiving social security benefits.) Enactment of this legislation would reduce outlays by $90 million in calendar year 1978 and $280 million in calendar year 1979.

2. *Limitation of retroactive benefits*

Under present law, social security retirement benefits are payable to workers and their spouses as early as age 62, with the benefits paid before age 65 actuarially and permanently reduced so that, on the average, the beneficiaries will get the same amount of lifetime benefits that they would receive if their benefits began at age 65. Benefits payable as early as age 60 to widows and widowers are also actuarially and permanently reduced when benefits are received for months prior to age 65.

Under present law, a person who files an application after he is first eligible for benefits may be paid benefits, including actuarially reduced benefits, for a retroactive period of up to 12 months before the month in which the application is filed, if all conditions of eligibility are met for those months.

Under the bill, except in those cases where the benefits were disability-related or where unreduced dependents benefits were involved, monthly benefits would not be paid retroactively for months before the month in which the application was filed where such retroactivity would result in permanently reduced benefits.

Under present law, the applicant-beneficiary who is eligible for reduced benefits may be faced with options that are unclear and misleading to him, and which could make it difficult for him to decide whether or not to elect reduced benefits. For example, if a worker's monthly benefit amount were $160 as of the month he attained age 65 and filed an application, his monthly benefit would be reduced to $149.40—a permanent reduction of $10.60 a month—if he chooses to take benefits for 12 months prior to the month he filed his application in order to get the one-time payment of $1,792.80.

Your committee has been concerned about the high proportion of applicants in such situations who choose to receive a relatively high one-time retroactive benefit payment, even though it means a permanent reduction in the monthly benefits they would get in the future. The retroactive payment is likely to be quickly used up, and, while some beneficiaries make up for the reduction in monthly benefits with supplemental security income (SSI) payments, many cannot qualify for these payments and their continuing income, on which they have to rely for the remainder of their lives, may be too small to provide for current needs. Under the change, this difficult choice would be removed and many older beneficiaries would have higher continuing incomes to meet their ongoing needs.

3. Early payment of social security and SSI benefit checks in certain situations

Under present law, social security benefit payments for a particular month are payable after the end of that month, and payment is normally made on the third day of the month; SSI benefit checks for a particular month are delivered on the first day of that month.

The bill would require that, when the delivery date for either payment falls on a Saturday, Sunday, or legal public holiday, the checks would be delivered on an earlier date.

The committee has been concerned that social security and SSI beneficiaries have to wait several days before they could get their benefit checks cashed in those instances where the delivery date fell on a Saturday, Sunday, or legal public holiday. Under the committee's bill, this situation would be alleviated.

Under the bill, if the usual delivery date for an SSI payment, for example, were September 1, and that date fell on a Monday that was a legal public holiday, the check would be paid on August 29. If the beneficiary were to die on, say, August 31, he would not be entitled to benefits for that month, and the check paid on August 29 would be erroneous. Your committee believes that any such erroneous payments that occur as a direct result of this provision should not be recovered. Therefore, the bill would provide that where an erroneous payment occurred under this provision, the erroneous payment would not be an overpayment, and therefore would not be recovered, if the event that caused the payment to be erroneous occurred after the check was delivered.

4. Relationship of the taxable earnings base under the railroad retirement program (Tier II) and the Pension Benefit Guaranty Corporation (PBGC).

The Railroad Retirement Act of 1974 restructured the railroad retirement program so that the benefits paid were divided into two parts—tier-I and tier-II. The tier-I benefit is essentially a social security benefit based on both railroad employment and non-railroad employment covered by social security. The benefit is financed out of a tax on employers and employees equal to the tax that would be paid under social security. Moreover, each time the social security tax base and tax rates are increased, an identical increase occurs in the railroad tier-I tax. Each year the tier-I taxes collected under the railroad program are transferred to the social security trust funds and the social security trust funds transfer to the railroad program the amount of social security benefits that would have been paid had railroad employment been covered under the social security program.

The tier-II benefit is an industry annuity program which is financed from a 9.5 percent tax on wages paid by employers without any contribution from employees. Both the amount of earnings taxed and the benefit paid are limited by the amount of earnings taxed under the social security program and rise as the social security tax base rises.

Although the tier II program is authorized by Federal law, financed by Federal taxes and administered by a Federal agency, the present program is the result of industry-wide negotiations between railway management and railway labor organizations. Your committee has been informed that railway labor and management are now engaged in industry-wide negotiations regarding wages, conditions of work and fringe benefits (including railroad retirement benefits), and that these negotiations could be prejudiced if the increases in the social security tax base included in the amendments reported by your committee were also to go into effect for purposes of tier-II of the Railroad Retirement Act. Your committee has no intention of affecting in any way these negotiations and the bill provides that the tier-II tax base and benefit computation base will be at the same levels they would have been under the automatic increase provision of the Social Security Act had your committee's bill not been enacted.

A somewhat similar situation exists with respect to the Pension Benefit Guaranty Corporation (PBGC) under the Employee Retirement Income Security Act of 1974 which provides for the insurance of pensions up to a certain maximum monthly amount. Initially, this was $750. The intent was that this amount should be automatically adjusted annually to reflect increases in the general level of wages. The mechanism was to increase the amount according to the increases in the Social Security maximum taxable earnings base, which under present law rises in accordance with increases in the general level of earnings. However, the ad hoc increases in the earnings base in the bill would have the unintended effect of increasing the maximum amount of pension insured under ERISA more than was the intention of the initial legislation. Accordingly, your committee's bill would rectify this situation by a technical change, so as to maintain the original intent. This would be done by tying the indexing of the insured pension amount under ERISA to the current Social Security earnings base as it would increase under current law had your committee's bill not been enacted.

IV. Actuarial Cost Estimates Under the Bill

A. ACTUARIAL SOUNDNESS OF THE OASDHI SYSTEM

In order to determine the financial soundness of the OASDHI system over a long-range period, the concept of long-range actuarial balance has normally been used. The long-range actuarial balance for OASDI is the difference between the 75-year average OASDI tax rate and the 75-year average expenditures expressed as a percentage of taxable payroll. The long-range actuarial balance for HI is calculated in a similar fashion, but over a 25-year period. If the difference is positive (that is, if the average tax rate exceeds the average expenditures), the system is said to have an actuarial surplus; if it is negative, the system is said to have an actuarial deficit. In addition, if that difference is less than 5 percent of the average expenditures, the system is said to be in close actuarial balance. In the past when there has been an actuarial imbalance (i.e., an actuarial deficit or actuarial surplus), the Congress has traditionally acted to revise either taxes or benefits, or both, so as to bring the program into close actuarial balance.

The provisions of the committee bill are summarized in the following section. The long-range cost of the OASDI system under the committee bill is estimated to be 13.42 percent of taxable payroll and the average OASDI tax rate is 11.73 percent which results in an "actuarial deficit" of 1.69 percent of taxable payroll. This is significantly lower than the deficit under present law of 8.20 percent of taxable payroll, but still outside the 5 percent limit of variation which is 0.67 percent of taxable payroll based on the estimated cost of 13.42 percent of taxable payroll.

The long-range cost of the HI system under the committee bill is estimated to be 3.53 percent of taxable payroll and the average HI tax rate is 2.69 percent. This results in a substantial "actuarial deficit" of 0.84 percent of taxable payroll, which is lower than the deficit under present law of 1.16 percent of taxable payroll, but still outside the 5 percent limit of variation for close actuarial balance, which is 0.18 percent of taxable payroll based on the estimated cost of 3.53 percent of taxable payroll.

B. ACTUARIAL COST ESTIMATES FOR THE OASDI SYSTEM

1. Effect of the bill on the actuarial balance of the OASDI system

From an actuarial cost standpoint, the major features of the bill are as follows:

a. Decoupling

Benefits are decoupled using a wage indexing procedure for those attaining age 62, dying or becoming disabled after 1978. For retirement cases, there would be a 10-year guarantee of the benefits that would result from the computation procedures in present law based on the benefit table in effect at the end of 1978.

b. Benefit level

The decoupling benefit formula would be designed to produce replacement rates that, on the average, are 5 percent lower than those projected under present law for the beginning of 1979.

c. Freezing the minimum benefit

The minimum PIA in the decoupling procedure would be frozen for all future years at the level shown in the benefit table in effect at the end of 1978.

d. Delayed retirement increment

Retirement benefits would be increased by 3 percent (instead of the 1 percent in present law) for every year that the beneficiary fails to receive benefits between ages 65 and 72.

e. Increase in retirement test

For beneficiaries aged 65 and over, the exempt amount in the earnings test would be increased to $4,000 in 1978, to $4,500 in 1979, and (as in present law) would automatically increase thereafter. For beneficiaries under age 65, the exempt amount would remain as in present law. The monthly measure would be eliminated except in the year of retirement.

f. Elimination of remarriage terminations

Remarriage would not be a cause for precluding or terminating entitlement to benefits.

g. Elimination of windfall for early retirees

Future percent increases in benefits would be applied to the amounts being paid, rather than to PIA's.

h. Universal coverage

Effective in 1982, coverage would be extended on a compulsory basis to all Federal, State and local government employees and employees of nonprofit organizations.

i. Increase in the taxable wage base

The taxable wage base for employers, employees, and self-employed persons would be increased to $19,900 in 1978; $22,900 in 1979; $25,900 in 1980; $27,900 in 1981; and as in present law would automatically increase thereafter.

j. Increase in self-employed tax rate

Effective in 1981 the OASDI tax rate for self-employed persons would be equal to 1½ times the rate for employees.

k. Tax rate increases

The tax rates would be increased as shown in tables 1 and 2.

TABLE 1.—CONTRIBUTION RATES FOR OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE UNDER PRESENT LAW AND UNDER THE COMMITTEE BILL

[In percent]

Calendar years	Employer and employee rate, each: Present law	Employer and employee rate, each: Committee bill	Self-employed rate: Present law	Self-employed rate: Committee bill[1]
1977	4.95	4.95	7	7.00
1978–80	4.95	5.05	7	7.10
1981–84	4.95	5.15	7	7.70
1985–89	4.95	5.45	7	8.20
1990–2010	4.95	6.00	7	9.00
2011 and later	5.95	6.00	7	9.00

[1] Approximately 1½ times the employee rate beginning in 1981.

TABLE 2.—CONTRIBUTION RATES FOR OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE UNDER THE BILL SUBDIVIDED BY TRUST FUND

[In percent]

Calendar years	Employer and employee rate, each: OASI	Employer and employee rate, each: DI	Employer and employee rate, each: Total	Self-employed rate: OASI	Self-employed rate: DI	Self-employed rate: Total
1977	4.375	0.575	4.95	6.185	0.815	7.00
1978	4.275	.775	5.05	6.010	1.090	7.10
1979–80	4.300	.750	5.05	6.045	1.055	7.10
1981–84	4.350	.800	5.15	6.500	1.200	7.70
1985–89	4.550	.900	5.45	6.850	1.350	8.20
1990 and later	4.900	1.100	6.00	7.350	1.650	9.00

The changes in the medium-range and long-range actuarial balances of the system from the levels under present law to those under the bill are shown in tables 3 and 4.

TABLE 3.—CHANGES IN ACTUARIAL BALANCE OF THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM OVER THE MEDIUM-RANGE PERIOD (1977–2001) EXPRESSED AS PERCENT OF TAXABLE PAYROLL, BY TYPE OF CHANGE, PRESENT LAW AND THE BILL

[In percent]

Item	OASI	DI	Total
Medium-range actuarial balance under present law	−1.45	−0.89	−2.34
Wage-indexing decoupling	.35	.19	.54
Benefit level	.26	.08	.33
Freezing the minimum benefit [1]	.03	.01	.04
Delayed retirement increment	−.04	0	−.04
Retirement test	−.05	0	−.05
Elimination of remarriage terminations	−.10	0	−.10
Elimination of windfall for early retirees	.13	0	.13
Universal coverage	.49	.07	.56
Miscellaneous provisions [2]	0	0	0
Increase in the taxable wage base	.41	.08	.48
Increase in self-employed tax rates	.08	.01	.09
Tax rate increases	.75	.56	1.31
Total effect of changes in bill	2.29	1.00	3.29
Medium-range actuarial balance under bill	.84	.10	.95

[1] Includes updating the special minimum and increasing it automatically after 1979.

[2] Includes equal treatment by sex (without the effect of any dependency test or pension offset provisions), employer liability for taxes on minimum wage for employees receiving tips, correction of the flaw in present law regarding limited partnerships, elimination of retroactive payments of actuarially reduced benefits, reducing marriage requirements from 20 yr to 5 yr for certain divorced beneficiaries, and annual reporting of earnings.

NOTES

Expenditures and taxable payroll are calculated under the intermediate set of assumptions (alternative II) which are described in the 1977 Report of the Board of Trustees of the Federal old-age and survivors insurance and disability insurance trust funds. These assumptions incorporate ultimate annual increases of 5¾ percent in average wages in covered employment and 4 percent in Consumer Price Index, an ultimate unemployment rate of 5 percent, and an ultimate total fertility rate of 2.1 children per woman. Taxable payroll is adjusted to take into account the lower contribution rates on self-employment income, on tips, and on multiple-employer "excess wages" as compared with the combined employer-employee rate.

Figures may not add due to rounding.

TABLE 4.—CHANGES IN ACTUARIAL BALANCE OF THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM OVER THE LONG-RANGE PERIOD (1977–2051) EXPRESSED AS PERCENT OF TAXABLE PAYROLL, BY TYPE OF CHANGE, PRESENT LAW AND THE BILL

[In percent]

Item	OASI	DI	Total
Long-range actuarial balance under present law	−6.06	−2.14	−8.20
Wage-indexing decoupling	3.19	.95	4.14
Benefit level	.53	.12	.66
Freezing the minimum benefit [1]	.07	.02	.09
Delayed retirement increment	−.09	0	−.09
Retirement test	−.07	0	−.07
Elimination of remarriage terminations	−.08	0	−.08
Elimination of windfall for early retirees	.24	0	.24
Universal coverage	.29	.05	.34
Miscellaneous provisions [2]	0	0	0
Increase in the taxable wage base	.36	.07	.43
Increase in self-employed tax rates	.09	.02	.11
Tax rate increases	.19	.56	.75
Total effect of changes in bill	4.73	1.78	6.51
Long-range actuarial balance under bill	−1.33	−.36	−1.69

[1] Includes updating the special minimum and increasing it automatically after 1979.

[2] Includes equal treatment by sex (without the effect of any dependency test or pension offset provisions), employer liability for taxes on minimum wage for employees receiving tips, correction of the flaw in present law regarding limited partnerships, elimination of retroactive payments of actuarially reduced benefits, reducing marriage requirements from 20 yr to 5 yr for certain divorced beneficiaries, and annual reporting of earnings.

NOTES

Expenditures and taxable payroll are calculated under the intermediate set of assumptions (alternative II) which are described in the 1977 Report of the Board of Trustees of the Federal old-age and survivors insurance and disability insurance trust funds. These assumptions incorporate ultimate annual increases of 5¾ percent in average wages in covered employment and 4 percent in Consumer Price Index, an ultimate unemployment rate of 5 percent, and an ultimate total fertility rate of 2.1 children per woman. Taxable payroll is adjusted to take into account the lower contribution rates on self-employment income, on tips, and on multiple-employer "excess wages" as compared with the combined employer employee rate.

Figures may not add due to rounding.

These medium-range and long-range estimates are based on the assumption that average earnings will increase after 1982 at an annual rate of 5¾ percent, and that the CPI will increase at 4 percent per year. Somewhat higher increases were assumed in the early years.

2. Income and outgo in near future for the OASDI system

Tables 5 through 7 show the progress of the OASI, DI, and the combined OASDI trust funds under present law in the past and under the bill in the future.

TABLE 5.—OPERATIONS OF THE OLD-AGE AND SURVIVORS INSURANCE TRUST FUND, CALENDAR YEARS 1972-87

[Amounts in billions]

Calendar year	Income	Disbursements	Net increase in fund	Funds at end of year	Fund at beginning of year as a percentage of disbursements during year	Fund at end of year as a percentage of disbursements during year
1972	$40.1	$38.5	$1.5	$35.3	88%	92%
1973	48.3	47.2	1.2	36.5	75	77
1974	54.7	53.4	1.3	37.8	68	71
1975	59.6	60.4	−.8	37.0	63	61
1976	66.3	67.9	−1.6	35.4	54	52
Estimated future experience:						
1977	72.5	75.6	−3.1	32.3	47	43
1978	80.6	83.6	−3.1	29.3	39	35
1979	90.8	92.7	−1.9	27.4	32	30
1980	100.8	101.3	−.4	26.9	27	27
1981	110.7	109.9	.8	27.8	25	25
1982	129.4	118.5	10.9	38.7	23	33
1983	140.5	127.5	12.9	51.6	30	40
1984	150.7	137.5	13.3	64.9	38	47
1985	168.2	148.3	19.9	84.8	44	57
1986	181.3	159.7	21.6	106.4	53	67
1987	194.4	171.9	22.5	128.8	62	75

TABLE 6.—OPERATIONS OF THE DISABILITY INSURANCE TRUST FUND, CALENDAR YEARS 1972-87

[Amounts in billions]

Calendar year	Income	Dishu.sements	Net increase in fund	Fund at end of year	Fund at beginning of year as a percentage of disbursements during year	Fund at end of year as a percentage of disbursements during year
1972	$5.6	$4.8	$0.8	$7.5	140%	157%
1973	6.4	6.0	.5	7.9	125	133
1974	7.4	7.2	.2	8.1	110	113
1975	8.0	8.8	−.8	7.4	92	84
1976	8.8	10.4	−1.6	5.7	71	55
Estimated future experience:						
1977	9.6	12.0	−2.4	3.3	48	27
1978	14.2	13.7	.5	3.8	24	28
1979	15.9	15.3	.6	4.4	25	29
1980	17.6	17.1	.5	4.9	26	28
1981	20.3	19.0	1.4	6.2	26	33
1982	24.0	20.9	3.1	9.3	30	45
1983	26.1	23.0	3.1	12.4	40	54
1984	28.0	25.3	2.6	15.0	49	59
1985	33.3	27.9	5.4	20.4	54	73
1986	36.2	30.7	5.5	25.9	66	84
1987	38.8	33.7	5.2	31.0	77	92

TABLE 7.—OPERATIONS OF THE OLD-AGE AND SURVIVORS INSURANCE AND THE DISABILITY INSURANCE TRUST FUNDS, COMBINED, CALENDAR YEARS 1972-87

[Amounts in billions]

Calendar year	Income	Disbursements	Net increase in funds	Funds at end of year	Funds at beginning of year as a percentage of disbursements during year	Funds at end of year as a percentage of disbursements during year
1972	$45.6	$43.3	$2.3	$42.8	93%	99%
1973	54.8	53.1	1.6	44.4	80	84
1974	62.1	60.6	1.5	45.9	73	76
1975	67.6	69.2	−1.5	44.3	66	64
1976	75.0	78.2	−3.2	41.1	57	53
Estimated future experience:						
1977	82.1	87.6	−5.5	35.6	47	41
1978	94.7	97.3	−2.5	33.1	37	34
1979	106.7	108.0	−1.3	31.7	31	29
1980	118.5	118.4	.1	31.8	27	27
1981	131.0	128.9	2.2	34.0	25	26
1982	153.4	139.4	14.0	48.0	24	34
1983	166.5	150.5	16.0	64.0	32	42
1984	178.7	162.8	15.9	79.8	39	49
1985	201.5	176.2	25.3	105.1	45	60
1986	217.4	190.4	27.1	132.2	55	69
1987	233.2	205.6	27.6	159.8	64	78

3. Increases in OASDI benefit disbursements and contribution income in 1978–87

The increases in the total benefit disbursements and contributions income of the old-age, survivors, and disability insurance system in calendar years 1978–87, as a result of the changes in the bill, are shown in tables 8 and 9.

TABLE 8.—ESTIMATED AMOUNT OF ADDITIONAL OASDI BENEFIT PAYMENTS IN CALENDAR YEARS 1978-87 UNDER THE PROVISIONS IN THE BILL

[In billions]

Calendar year	Additional benefits		
	OASI	DI	OASDI
1978	−$0.4	(1)	−$0.4
1979	.7	(1)	.7
1980	.7	−$0.2	.5
1981	.5	−.4	(1)
1982	.1	−.8	−.6
1983	−.3	−1.1	−1.4
1984	−.7	−1.4	−2.1
1985	−1.1	−1.8	−2.9
1986	−1.6	−2.2	−3.7
1987	−2.0	−2.7	−4.6

[1] Less than $50,000,000.

TABLE 9.—ADDITIONAL CONTRIBUTION INCOME RESULTING FROM THE COMMITTEE BILL IN CALENDAR YEARS 1978–83, BY PROVISION

[In billions]

Calendar year	Increase in contribution and benefit base	Reallocation of tax rates between OASDI and HI	Increase in OASDI self-employment tax rate to 1½ times employee rate	Increase in tax rates	Subtotal, excluding universal coverage	Additional amount due to universal coverage	Total additional amount[1]
OASDI:							
1978	$2.3	$1.7			$4.0		$4.0
1979	4.6	2.0			6.6		6.7
1980	6.3	2.3			8.5		8.6
1981	7.0	1.3	$0.1	$3.4	11.8		11.9
1982	7.5	1.3	.4	4.0	13.2	$11.7	25.0
1983	7.9	1.4	.4	4.3	14.0	14.2	28.3
HI:							
1978	.5	−1.7			−1.2		−1.2
1979	1.0	−2.0			−1.0		−1.0
1980	1.4	−2.3			−.9		−.9
1981	1.8	−1.3			.5		.5
1982	2.0	−1.3			.7	3.0	3.7
1983	2.1	−1.4			.7	3.6	4.3
Total:							
1978	2.8				2.8		2.8
1979	5.6				5.6		5.6
1980	7.6				7.6		7.7
1981	8.8		.1	3.4	12.3		12.3
1982	9.5		.4	4.0	13.9	14.7	28.7
1983	10.0		.4	4.3	14.7	17.8	32.6

[1] Includes relatively small amounts of additional taxes payable by employers on employees' income from tips.

4. Long-range OASDI cost projections

Table 9 shows the long-range cost estimates of the OASDI system as modified by the bill and as compared with the taxes provided.

TABLE 10.—ESTIMATED EXPENDITURES OF OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM AS PER CENT OF TAXABLE PAYROLL UNDER THE BILL, FOR SELECTED YEARS 1977–2055

[In percent]

Calendar year	Expenditures as percent of taxable payroll[1]				
	Old-age and survivors insurance	Disability insurance	Total	Tax rate in bill	Difference
1977	9.39	1.50	10.89	9.90	−0.99
1978	9.05	1.48	10.52	10.10	−.42
1979	8.91	1.47	10.38	10.10	−.28
1980	8.74	1.48	10.22	10.10	−.19
1981	8.72	1.51	10.22	10.30	.01
1982	7.99	1.41	9.40	10.30	.93
1983	8.05	1.45	9.50	10.30	.80
1984	8.12	1.50	9.62	10.30	.69
1985	8.20	1.55	9.75	10.90	1.14
1986	8.27	1.59	9.86	10.90	1.01
1987	8.34	1.63	9.97	10.90	.93
1988	8.36	1.69	10.05	10.90	.86
1989	8.37	1.75	10.12	10.90	.72
1990	8.38	1.81	10.19	12.00	1.88
1991	8.38	1.86	10.24	12.00	1.70
1992	8.39	1.90	10.29	12.00	1.78
1993	8.39	1.95	10.34	12.00	1.60
1994	8.41	2.00	10.40	12.00	1.65
1995	8.42	2.05	10.47	12.00	1.58
1996	8.41	2.10	10.51	12.00	1.43
1997	8.40	2.16	10.56	12.00	1.44
1998	8.40	2.21	10.62	12.00	1.35
1999	8.41	2.27	10.68	12.00	1.33
2000	8.42	2.32	10.74	12.00	1.26
2001	8.45	2.38	10.83	12.00	1.12
2005	8.57	2.62	11.19	12.00	.88
2010	9.21	2.77	11.98	12.00	.01
2015	10.40	2.96	13.36	12.00	−1.32
2020	11.94	2.99	14.93	12.00	−2.96
2025	13.45	2.88	16.33	12.00	−4.37
2030	14.31	2.75	17.06	12.00	−5.08
2035	14.41	2.67	17.08	12.00	−5.06

TABLE 10.—ESTIMATED EXPENDITURES OF OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM AS PERCENT OF TAXABLE PAYROLL UNDER THE BILL, FOR SELECTED YEARS 1977-2055—Continued

[In percent]

Calendar year	Expenditures as percent of taxable payroll [1]			Tax rate in bill	Difference
	Old-age and survivors insurance	Disability insurance	Total		
2040	13.94	2.68	16.62	12.00	−4.62
2045	13.47	2.76	16.23	12.00	−4.23
2050	13.32	2.79	16.11	12.00	−4.11
2055	13.38	2.80	16.18	12.00	−4.18
25-yr averages:					
1977–2001	8.45	1.80	10.25	11.20	.9
2002–25	10.52	2.82	13.34	12.00	−1.35
2027–51	13.89	2.74	16.63	12.00	−4.64
75-yr average: 1977–2051	10.96	2.46	13.42	11.73	−1.67

[1] Expenditures and taxable payroll are calculated under the intermediate set of assumptions (alternative II) which are described in the 1977 Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds. These assumptions incorporate ultimate annual increases of 5¾ percent in average wages in covered employment and 4 percent in Consumer Price Index, an ultimate unemployment rate of 5 percent, and an ultimate total fertility rate of 2.1 children per woman. Taxable payroll is adjusted to take into account the lower contributions rates on self-employment income, on tips, and on multiple-employer "excess wages" as compared with the combined employer-employee rate.

It may be noted from table 9 that the OASDI tax rates scheduled in the commitee's bill would exceed the yearly costs for at least the next 30 years. Under the proposed tax schedule there would be a significant accumulation of trust funds as may be observed from table 10. However, due to the projected long-range actuarial imbalance, the trust funds are eventually exhausted. This is projected to occur around the year 2009 for the disability insurance program and around the year 2029 for the old-age and survivors insurance program.

TABLE 11.—TRUST FUND RATIOS: FUNDS AT BEGINNING AND END OF YEAR AS A PERCENTAGE OF DISBURSEMENTS DURING YEAR

[In percent]

Calendar year	Funds at beginning of year as a percentage of disbursements during year			Funds at end of year as a percentage of disbursements during year		
	OASI	DI	Total	OASI	DI	Total
1977	47	48	47	43	27	41
1978	39	24	37	35	23	34
1979	32	25	31	30	29	29
1980	27	26	27	27	28	27
1981	25	26	25	25	33	26
1982	23	30	24	33	45	34
1983	30	40	32	40	54	42
1984	38	49	39	47	59	49
1985	44	54	45	57	73	60
1986	53	66	55	67	84	69
1987	62	77	64	75	92	78
1988	71	84	73	84	95	86
1989	79	87	80	93	95	93
1990	88	87	87	111	115	112
1991	104	106	105	129	132	130
1992	121	121	121	147	145	146
1993	138	133	137	164	156	163
1994	154	143	152	182	163	178
1995	171	150	166	199	167	193
1996	187	153	181	217	168	207
1997	204	154	194	235	167	221
1998	221	153	207	253	163	234
1999	238	149	219	271	156	246
2000	255	143	230	288	148	258
2001	270	135	240	305	136	268
2005	328	84	271	365	73	296
2010	364	(1)	[2] 278	394	(1)	[2] 297
2015	339	(1)	[2] 238	355	(1)	[2] 244
2020	257	(1)	[2] 157	256	(1)	[2] 147
2025	138	(1)	[2] 44	119	(1)	[2] 19
2030	(3)	(1)	[2] −91	(3)	(1)	[2] −128

[1] Fund exhausted in 2009.

[2] Figures are theoretical because it is estimated that the disability trust fund will be exhausted in 2009.

[3] Fund exhausted in 2029.

C. BASIC ASSUMPTIONS FOR COST ESTIMATES FOR OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM

1. General basis for long-range cost estimates

The long-range estimates for the old-age, survivors, and disability insurance program presented in this report are based on the assumption that average earnings in covered employment will increase after 1982 at an annual rate of 5¾ percent. Similarly, the assumption has been made that the CPI will increase at an annual rate of 4 percent. Higher increases for both earnings and CPI are assumed for the yearly years. These assumptions yield, over the long-range, an implied increase in real earnings of 1¾ percent per year, which is based on the actual average experience of the last 25 years (estimated at about 1.7 percent per year based on annual averages for the period 1956–76), although recent experience has been much lower (about 1.1 percent in the last 15 years and 0.5 percent in the last 10 years based on annual averages).

The estimates reflect the effects under present law and under the system as it would be modified by the committee bill of various changes assumed to occur as a result of the automatic provisions. Table 11 summarizes those changes.

TABLE 12.—ASSUMED FUTURE CHANGES RESULTING FROM AUTOMATIC PROVISIONS UNDER PRESENT LAW AND UNDER THE COMMITTEE BILL

Calendar year	General benefit increase [1] (percent)	Contribution and benefit base		Annual exempt amount under the retirement test	
		Present law [2]	Committee bill [3]	Present law	Committee bill [4]
1977	5.9	$16,500	$16,500	$3,000	$3,000
1978	5.5	17,700	19,900	3,240	4,000
1979	5.2	18,900	22,900	3,480	4,500
1980	5.0	20,400	25,900	3,720	4,920
1981	4.2	21,900	27,900	3,960	5,280

[1] Under present law, applies to both persons eligible for benefits at the time of the benefit increase and to persons becoming eligible for benefits thereafter. Under the Committee bill, applies only to persons eligible for benefits as of the time of the benefit increase, for years after 1978.

[2] Under present law, the contribution and benefit base for each year is determined under the automatic increase provisions of the law.

[3] Under the Committee bill, the increases in the contribution and benefit base in each year 1978–81 are ad hoc increases. For years after 1981, the base is determined under the automatic increase provisions of the law.

[4] The higher exempt amounts under the Committee bill apply only to those beneficiaries subject to the retirement test who are aged 65 and over. The exempt amounts that are provided under present law would continue to apply to beneficiaries who are under age 65.

It should be observed that the assumptions of constant annual increases in the CPI were not adopted because it was felt that these increases would remain constant in the future. These assumptions are intended to represent average increases over the long-range future, with the increases being higher in some years and lower in others.

The long-range cost projections are based on assumptions that are intended to represent close to full employment (average unemployment is assumed at 5 percent of the labor force).

The long-range cost estimates presented in this report were prepared for a 75-year period. A valuation period of this length has been selected because it approximates the life span of the current working population.

2. Measurement of costs in relation to taxable payroll

Long-range costs included in this report are expressed as a percentage of taxable payroll. This measure is used because it is directly comparable to the combined employer-employee tax rate. Because of this characteristic the adequacy of any tax schedule can be readily determined and new tax schedules can be readily designed to meet the cost of the program.

D. ACTUARIAL COST ESTIMATES FOR THE HI SYSTEM

1. Effect of the bill on the actuarial balance of the HI system

From an actuarial cost standpoint, the major features of the bill that affect the HI system are as follows:

a. Universal coverage

Effective in 1982, coverage would be extended on a compulsory basis to all Federal, State, and local government employees and employees of non-profit organizations.

b. Increase in the taxable wage base

The taxable wage base for employers, employees, and self-employed persons would be increased to $19,000 in 1978; $22,900 in 1979; $25,900 in 1980; and $27,900 in 1981. As in present law, the wage base would increase automatically thereafter.

c. Tax rate decreases

The tax rates would be decreased, as shown in table 12.

The changes in the actuarial balance of the HI system, from a deficit of 1.16 percent of taxable payroll under present law to a deficit of 0.84 percent under the bill, are shown in table 13.

2. Short-range estimates of the income and outgo of the HI system

Table 14 shows the progress of the HI trust fund under present law in the past and under the bill in the future.

3. Long-range estimates for the HI system.

The adequacy of a schedule of contribution rates to support the HI system is measured by comparing on a year-to-year basis the tax rates with the corresponding total costs of the program, expressed as percentages of taxable payroll. The total cost of the program in any year essentially is the combined employer-employee contribution rate that will be sufficient to (a) provide the benefit payments and administrative expenses for the year for insured beneficiaries and (b) build the trust fund to the level of a year's disbursements and maintain it at that level. If the tax rate and the total cost (expressed as a percentage of taxable payroll) are exactly equal in each year of the 25-year projection period and all projection assumptions are realized, tax revenues along with interest income will be sufficient to provide for benefits and administrative expenses for insured persons and to build the trust fund gradually to the level of a year's outgo by the end of the period. To the extent that small differences between the yearly costs of the program and the corresponding tax rates occur for short periods of time and are offset by subsequent differences in the reverse direction, adequate financing will have been provided.

Table 15 shows the long-range cost estimates of the HI system as modified by the bill and as compared with the taxes provided. As indicated in this table, the HI tax rates scheduled in the bill would be less than the total costs in nearly every year of the 25-year projection period. Under the proposed tax schedule, the assets in the trust fund decline as a percentage of a year's outgo from a level of 77 percent at the beginning of 1976 to a level of approximately 50 percent during the mid-1980's. As shown in table 16, the assets in the trust fund decline very rapidly in the late 1980's, with the fund projected to be exhausted completely in 1991.

TABLE 13.—CONTRIBUTION RATES FOR HOSPITAL INSURANCE UNDER BILL, AS COMPARED WITH THOSE UNDER PRESENT LAW

[In percent]

	Employer, employee, and self-employed rate, each	
	Present law	Bill
Calendar year:		
1977	0.90	0.90
1978	1.10	1.00
1979–80	1.10	1.00
1981–84	1.35	1.30
1985	1.35	1.30
1986–2001	1.50	1.45

TABLE 14.—*Changes in actuarial balance of the hospital insurance system expressed as percent of taxable payroll, by type of change, present law and the bill*

Item	*Percent*
Actuarial balance under present law	−1.16
Universal coverage	+.24
Increase in wage base for employers	+.10
Increase in wage base for employees and self-employed persons	+.09
Revised tax schedule	−.11
Total effect of changes in bill	+.32
Actuarial balance under bill	−.84

NOTE.—Expenditures and taxable payroll are calculated under the intermediate set of assumptions (alternative II) which is described in the 1977 Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund. These assumptions incorporate ultimate annual increases of 5¾ percent in average wages in covered employment and 4 percent in Consumer Price Index, an ultimate unemployment rate of 5 percent, and an ultimate total fertility rate of 2.1 children per woman. Taxable payroll is adjusted to take into account the lower contribution rate on self-employment income, on tips, and on multiple-employer "excess wages" as compared with the combined employer-employee rate.

TABLE 15.—PROGRESS OF THE SOCIAL SECURITY HOSPITAL INSURANCE TRUST FUND UNDER BILL, CALENDAR YEARS 1972–87

[Amounts in billions]

Calendar year:	Income	Disbursements	Net increase in fund	Fund at end of period	Fund at beginning of year as a percentage of disbursements during year
1972	$6.4	$6.5	−$0.1	$2.9	47%
1973	10.8	7.3	3.5	6.5	40
1974	12.0	9.4	2.7	9.1	69
1975	13.0	11.6	1.4	10.5	79
1976	13.8	13.7	.1	10.6	77
Estimated future experience:					
1977	16.1	16.2	−.1	10.5	66
1978	19.7	19.0	.6	11.1	55
1979	22.3	22.2	.1	11.2	50
1980	24.5	25.7	−1.2	10.0	44
1981	33.5	29.7	3.8	13.8	34
1982	39.7	33.9	5.8	19.6	41
1983	43.1	38.5	4.6	24.2	51
1984	46.1	43.7	2.4	26.6	55
1985	49.0	49.2	−.1	26.5	54
1986	57.5	55.0	2.5	29.0	48
1987	61.7	61.4	.3	29.4	47

Note: Figures may not add due to rounding.

TABLE 16.—ESTIMATED COST OF HOSPITAL INSURANCE SYSTEM AS PERCENT OF TAXABLE PAYROLL UNDER THE BILL, FOR CALENDAR YEARS 1977–2001

[In percent]

Calendar year:	Expenditures under the program [1]	Trust fund building and Maintenance [2]	Total cost of the program	Tax rate in bill [3]	Difference
1977	1.99	0.15	2.14	1.80	−0.34
1978	2.04	.15	2.19	2.00	−.19
1979	2.13	.14	2.27	2.00	−.27
1980	2.22	13	2.35	2.00	−.35
1981	2.36	.12	2.48	2.60	.12
1982	2.29	.12	2.41	2.60	.19
1983	2.44	.12	2.56	2.60	.04
1984	2.60	.11	2.71	2.60	−.11
1985	2.75	.11	2.86	2.60	−.26
1986	2.89	.11	3.00	2.90	−.10
1987	3.03	.11	3.14	2.90	−.24
1988	3.17	.11	3.28	2.90	−.38
1989	3.33	.10	3.43	2.90	−.53
1990	3.49	.10	3.59	2.90	−.69
1991	3.65	.10	3.75	2.90	−.85
1992	3.80	.10	3.90	2.90	−1.00
1993	3.97	.10	4.07	2.90	−1.17
1994	4.13	.10	4.23	2.90	−1.33
1995	4.30	.09	4.39	2.90	−1.49
1996	4.43	.09	4.52	2.90	−1.62
1997	4.57	.09	4.66	2.90	−1.76
1998	4.71	.09	4.80	2.90	−1.90
1999	4.85	.09	4.94	2.90	−2.04
2000	5.01	.09	5.10	2.90	−2.20
2001	5.16	.09	5.25	2.90	−2.35
Average [4]	3.42	.11	3.53	2.69	−.84

[1] Ratio of benefit payments and administrative expenses for insured beneficiaries to taxable payroll. Taxable payroll is adjusted to take into account the lower contribution rates on self-employment income, on tips, and on multiple-employer "excess wages."

[2] Allowance for building the trust fund balance to the level of a year's outgo and maintaining it at that level, after accounting for the offsetting effects of interest earnings.

[3] Rate for employers and employees, combined.

[4] Average for the 25-yr period 1977–2001.

TABLE 17.—*HI trust ratios: fund at beginning of year as a percentage of disbursements during year*

Calendar year:	*Fund at beginning of year as a percentage of disbursement during year*
1977	66
1978	55
1979	50
1980	44
1981	34
1982	41
1983	51
1984	55
1985	54
1986	48
1987	47
1988	42
1989	34
1990	22
1991	7
1992 and later	([1])

[1] Trust fund exhausted in 1992.

V. SECTION-BY-SECTION ANALYSIS OF THE BILL

TITLE I—PROVISIONS TO IMPROVE THE FINANCING OF THE OLD-AGE, SURVIVORS, AND DISABILTY INSURANCE PROGRAM

Section 101. Adjustments in tax rates

Section 101 of the bill provides for shifting to the OASDI program 0.10 percent of the 0.2 percent tax rate increase already scheduled in present law for 1978–80 for the health insurance program, and restoring 0.05 percent of the shift in 1981 and after for increasing tax rates for employees and employers, each by 0.15 percent, 0.30 percent, and 0.55 percent, in 1981, 1985, and 1990, respectively, and for restoring the OASDI tax rate for the self-employed to 1½ times the employee tax rate.

Old-age, survivors, and disability insurance tax rates

Section 101(a) of the bill amends sections 3101(a), 3111(a) and 1401(a) of the Internal Revenue Code of 1954 to provide a new schedules of old-age, survivors, and disability insurance tax rates for employees, employers, and the self-employed.

Subsection (a) of the amended section 3101 and subsection (a) of the amended section 3111 provide new schedules of tax rates on wages for purposes of old-age, survivors, and disability insurance. Under present law, these tax rates for employees and employers, each, are as follows:

Calendar years:	*Percent*
1977–2010	4.95
2011 and after	5.95

Under the bill, the tax rates on wages for both employees and employers for old-age, survivors, and disability insurance are as follows:

Calendar years:	*Percent*
1977	4.95
1978 to 1980	5.05
1981 to 1984	5.15
1985 to 1989	5.45
1990 and after	6.0

Subsection (a) of the amended section 1401 provides new schedules of tax rates for self-employment income for purposes of old-age, survivors, and disability insurance. Under present law, the OASDI tax rate for the self-employed is 7 percent for all taxable years beginning after 1972.

Under the bill, the tax rates in self-employment income for old-age, survivors, and disability insurance are as follows:

Taxable years beginning after:	Percent
1972 (and before 1978)	7.00
1977 (and before 1981)	7.10
1980 (and before 1985)	7.70
1984 to 1989	8.20

Hospital insurance rates

Section 101(b) of the bill amends sections 3101(b), 3111(b), and 1401(b) of the Code to provide new schedules of hospital insurance tax rates for employees, employers, and the self-employed.

Subsection (b) of the amended section 3101 and subsection (b) of the amended section 3111 provide new schedules of tax rates on wages for purposes of hospital insurance. Under present law, these tax rates are as follows:

Calendar years:	Percent
1977	0.90
1978–80	1.10
1981–85	1.35
1986 and after	1.50

Under the bill, the tax rates on wages for employees and employers, each, for hospital insurance are as follows:

Calendar years:	Percent
1977	0.90
1978–80	1.00
1981–85	1.30
1986 and after	1.45

Subsection (b) of the amended section 1401 provides a new schedule of tax rates on self-employment income for purposes of hospital insurance.

Under present law, these tax rates are as follows:

Taxable years beginning after:	Percent
1973 (and before 1978)	0.90
1977 (and before 1981)	1.10
1980 (and before 1986)	1.35
1985	1.50

Under the bill, the tax rates on self-employment income for hospital insurance are as follows:

Taxable years beginning after:	Percent
1973 (and before 1978)	0.90
1977 (and before 1981)	1.00
1980 (and before 1987)	1.30
1985	1.45

Section 102. Allocations to disability insurance trust fund

Section 102(a)(1) of the bill amends section 201(b)(1) of the Social Security Act which deals with the amount to be allocated and appropriated to the Federal Disability Insurance Trust Fund each year with respect to wages. Under present law, the amounts so allocated and appropriated with respect to wages paid are as follows:

Calendar year:	*Percent*
1977	1.150
1978–80	1.200
1981–85	1.300
1986–2010	1.400
2011 and after	1.700

Under the amended section 201(b)(1), the amount so allocated and appropriated will be as follows:

Calendar years:	*Percent*
1977	1.150
1978	1.550
1979–80	1.500
1981–84	1.600
1985–89	1.800
1990 and after	2.200

Section 102(a)(2) of the bill amends section 201(b)(2) of the Act, which deals with the amount to be allocated and appropriated to the Federal Disability Insurance Trust Fund each year with respect to self-employment income. Under present law the amounts so allocated and appropriated with respect to any self-employment income reported for a taxable year are as follows:

Taxable years beginning after:	*Percent*
1973 (and before 1978)	0.815
1977 (and before 1981)	.850
1980 (and before 1986)	.920
1985 (and before 2011)	.990
2010	1.000

Under the amended section 201(b)(2), the amounts so allocated and appropriated will be as follows:

Taxable years beginning after:	*Percent*
1973 (and before 1978)	0.815
1977 (and before 1979)	1.090
1978 (and before 1981)	1.065
1980 (and before 1985)	1.200
1984 (and before 1990)	1.350
1989	1.650

Section 103(a)(1) of the bill amends section 230(a) of the Act to provide that the Secretary will publish the *ad hoc* increases in the contribution and benefit base provided in subsection (c) in the Federal Register on or before November 1 of the year before the year they are to be effective. This change is needed because the *ad* hoc base increases for 1978–1981 are considered to be determined under subsection (b) as though they were automatic increases.

Section 103(a)(2) of the bill amends section 230(b) of the Act to take account of the *ad hoc* base increases provided in subsection (c).

Section 103(b) of the bill amends section 230(c) of the Act to provide for *ad hoc* increases in the base applicable to employees, employers, and the self employed to $19,900 in 1978, $22,900 in 1979, $25,900 in 1980, and $27,000 in 1981. For years after 1981, the base will be automatically adjusted as under present law with the 1981 base to be used as the starting point for computing subsequent bases under this section. For purposes of computing tier II pensions under the Railroad Retirement Act of 1974 the contribution and benefit base will be the contribution and benefit base in effect as if this act had not been enacted.

Section 103(c)(1) provides that the contribution and benefit base determined under section 230 of the Act to compute the monthly insurance benefits guaranteed by the Pension Benefit Guaranty Corporation under P.L. 93–406 (ERISA) shall be the contribution and benefit base in effect as if this Act had not been enacted.

Section 103(d) of the bill amends section 215(i)(2)(D) of the Act to specify how the amounts to be included on the last line of Columns III and IV in the benefit table will be determined when the table is extended to reflect new AME levels possible under a new contribution and benefit base and the new base is not divisible by 12.

Section 104. Standby guarantee of trust fund levels

Section 104 of the bill provides standby authority for automatic loans from the general revenues of the Government to the social security trust funds whenever the assets of the old-age and survivors insurance or disability insurance trust fund at the end of any calendar year after 1977 are below 25 percent of the total outgo from that fund during that year. The section also provides for repayment of any such loan or loans and temporary tax-rate increases to provide funds to repay the loans.

Section 104(a) of the bill amends section 201 of the Act by adding a new subsection (j) which provides, in paragraph (1) thereof, that if at the close of any calendar year after 1977 the balance remaining in the Federal Old-Age and Survivors Insurance Trust Fund or the Federal Disability Insurance Trust Fund (as determined by the Secretary of the Treasury in the following February) is less than 25 percent of the total amount of the expenditures made from such fund under Title II of the Act during that calendar year, there is automatically appropriated to the Secretary of the Treasury for loan to such fund as of the following July 1 an amount equal to the difference between such balance and 27½ percent of such total amount.

Paragraph 2 of the new subsection (j) provides that if at the close of any calendar year succeeding a year for which a loan was made under paragraph (1), (A) the balance remaining in the fund (as determined by the Secretary of the Treasury in the following February) is less than 35 percent of the amount of expenditures made from such fund during such succeeding year, and (B) the outstanding balance of all loans (including interest) which were made to the fund with respect to years before such succeeding year is $2 billion or more, the tax rates set by sections 1401(a), 3101(a), and 3111(a) of the Internal Revenue Code of 1954 (self-employment, employee and employer rates, respectively) will be increased as provided in section 3125 of the Code (provided by section 104(b) of the bill, described below) in the second calendar year after such succeeding year.

Paragraph (3) of the new subsection (j) provides that any amount appropriated for loans to either the old-age and survivors insurance or disability insurance trust fund with respect to any calendar year under paragraph (1) shall be repaid, with interest, by transfer from such fund to the general fund of the Treasury as follows: A repayment shall be made on July 1 next succeeding any subsequent calendar year at the close of which (as determined by the Secretary of the Treasury in the following February) the balance remaining in such funds exceeds 30 percent of the total amount of the expenditures made from such fund under Title II of the Social Security Act during that calendar year; the amount of the repayment will be equal to the difference between (A) such balance, and (B) 30 percent of the total amount of such expenditures.

Paragraph (a) also provides that interest on loans made under paragraph (1) shall be at a rate, as determined by the Secretary of the Treasury, equal to the average market yield on the outstanding marketable obligations of the United States of comparable maturities at the time the loan was made.

Section 104(b) of the bill amends chapter 21 of the Internal Revenue Code of 1954 by redesignating sections 3125 and 3126 as sections 3126 and 3127, respectively, and by adding a new section 3125 which provides that whenever an appropriation has been made under the new section 201(j)(1) for loans to the old-age and survivors insurance or disability insurance trust fund, and the new section 201(j)(2) applies with respect to a succeeding calendar year, as described above, the tax rate for employees and employers, each, which would otherwise be in effect (under sections 3101(a) and 3111(a) of the Code) with respect to wages received or paid in the 2nd calendar year after such succeeding year will be increased by 0.10 percent and the tax rate for the self-employed which would otherwise be in effect (under section 1401 (a) of the Code) with respect to taxable years beginning in the second year after such succeeding year, will be increased by 0.15 percent.

Section 104(b) of the bill also amends the table of sections of Chapter 21 of the Code to take account of the redesignated and new sections, and amends section 1401(a) of the Code (as amended by section 101 (a)(3) of the bill), and sections 3101(a) and 3111(a) of the Code (as amended by sections 101(a) (1) and (2) of the bill) to add appropriate conforming references to the new section 3125.

Section 105. Effective date

Section 105 of the bill provides that the amendments made by sections 101, 102, and 103 are to apply with respect to remuneration paid or received after 1977 and to taxable years beginning after 1977. Section 105 further provides that the amendments made by section 104 shall apply with respect to calendar years after 1977.

TITLE II—STABILIZATION OF REPLACEMENT RATES IN THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE PROGRAM

General

Section 201 of the bill amends section 215 of the Social Security Act to provide a new method for calculating a worker's average earnings for benefit purposes and for determining primary insurance amounts (PIA's). This section also provides for a transition from the present to the new system in the case of workers reaching age 62 in the first

10 years under the new system and makes other benefit adjustments. Section 201 of the bill specifically provides for:

1. A new benefit formula for computing the PIA of workers who become eligible for old-age insurance benefits, become disabled, or die after 1978, which would be automatically updated to future changes in average wages;
2. Application of the new PIA formula to earnings that are indexed to take account of changes in average wage levels during the workers' lifetimes;
3. A transitional provision that guarantees workers who become age 62 in the period 1979–1988 that their retirement benefits will be no less than the amount derived from the table in the law in December 1978 with cost-of-living increases beginning only with eligibility (age 62);
4. A restatement of recomputation provisions (largely similar to present law) for workers who reach age 62, become disabled, or die after 1978;
5. An increase in the special minimum to a maximum of $230 (instead of $180 as under present law) and future automatic cost-of-living adjustments in special minimum PIA's; and
6. A regular minimum benefit frozen at the level under present law as of implementation (about $121 in January 1979) with cost-of-living increases beginning with the year the worker reaches age 62, becomes disabled, or dies.

Computation of primary insurance amount

Section 201(a) of the bill provides a new section 215(a) of the Act. Paragraph (1) of the new section 215(a) provides for the basic PIA computation.

Subparagraphs (A) and (B) of the new section 215(a)(1) provide a formula for computing PIA's based on average indexed monthly earnings (AIME) and for automatically adjusting the formula in the future to increases in average wages in the economy. Subparagraph (A) of the new section 215(a)(1) specifies that factors in the new formula will be 90 percent for the lower part of the worker's AIME, 32 percent of the next higher portion of AIME, and 15 percent of remaining additional AIME. (These percentage factors will not be subject to automatic change in the future.) Subparagraph (A) further provides that the PIA will be the sum of the application of these percentages to the appropriate portions of AIME, rounded up (if necessary) to the next higher multiple of $0.10 and increased under the automatic cost-of-living adjustment provisions.

Subparagraph (B) of the new section 215(a)(1) specifies the AIME levels to which the percentage factors in the formula would apply for 1979 and to whom the formula applies. For people who reach age 62, become disabled, or die in 1979, the formula will be: 90 percent of the first $180 of AIME, plus 32 percent of AIME above $180 but not above $1085, plus 15 percent of AIME above $1085. For those who reach age 62, become disabled, or die in each year after 1979, the 1979 amounts ($180 and $1085) will be automatically adjusted to wages by multiplying them by the ratio of: Average wages for the second year before the year for which the determination is made to average wages in 1977. The resulting amounts (formula brackets) will be rounded to the nearest $1, (or to the new higher $1, if an exact multiple of $0.50 but not of $1). Thus, in computing a worker's PIA, the formula that applies is the one determined for the earliest of the year of eligibility for old-age benefits (age 62), onset of disability, or death.

For purposes of subparagraph (B), average wages means the average of total annual wages (as reported to the Secretary of the Treasury) as defined in the regulations of the Secretary (of HEW) and without regard to the contribution and benefit base limitation. (It is anticipated that, pursuant to regulations, Forms 1040 for 1977 and 1978 will be used in determining average wages for those years, and Forms W-2 for 1978 and later years will be used in determining average wages for years after 1978. The data will, beginning in 1977, include the reports of wages for employment both covered and not covered under the Act, and will include wages in excess of the contribution and benefit base.)

Subparagraph (C) of the new section 215(a)(1) provides that no PIA as computed under the new formula will be less than the greater of (1) the minimum PIA in the benefit table in the law in effect in December 1978, and rounded (if necessary) to the next multple of $1.00; or (2) the "special minimum" PIA. The minimum PIA will not be automatically adjusted to increases in the Consumer Price Index (CPI) as provided under subsection (i) until a worker reaches age 62, becomes disabled, or dies. This subparagraph also provides that, for 1979, the special minimum will equal $11.50 times the number of a worker's years of coverage over 10 and up to (and including) 30. The special minimum will be automatically adjusted to increases in the CPI as provided under subsection (i) as amended by this bill for years after 1978. (Under present law, the dollar amount used to compute a special minimum benefit has been $9.00 since the 1973 amendments.)

The new subparagraph (C) also restates the present-law definition of a year of coverage (the total number of which cannot exceed 30) for purposes of computing a special minimum benefit. The number of years of coverage for 1937–50 is determined by dividing total wages credited for that period by $900 disregarding any fraction. The resultant number cannot exceed 14. The number of years of coverage after 1950 (excluding years wholly within a period of disability) is the number of years in which earnings equal no less than 25 percent of the contribution and benefit base in effect in each year.

For 1977, the base is $16,500 and 25 percent of the base is $4125. To maintain the present measure of a year of coverage in relation to average wages, a new provision is added under which for purposes of the special minimum provision the base for years after 1977 will be limited to the amount that would be in effect for those years if present law remained in effect without change.

Subparagraph (D) of the new section 215(a)(1) specifies that in each year after 1978, the Secretary is to publish by November 1 the benefit formula applicable for the following calendar year and the average wages on which the formula is based. The formula for a given year will be applicable to those who reach age 62, have an onset of disability, or die in that year. The Secretary is also required to publish by November 1979, average wages for each year after 1950.

Paragraph (2) of the new section 215(a) provides for exceptions to the basic PIA computation outlined in paragraph (1) in certain cases involving disability insurance benefits.

Subparagraph (A) of the new section 215(a)(2) provides that where a worker was entitled to disability benefits in any of the 12 months before he reaches age 62, has a new onset of disability or dies, the year he reaches age 62, has the new onset of disability or dies will not count as a year of eligibility for purposes of sections 215(a), (b), and (i) as amended by this Act. In such cases, the year of eligibility will be the year of onset of the prior disability.

Subparagraph (B) of the new section 215(a)(2) provides that where a worker was entitled to disability benefits in any of the 12 months before he became entitled to a retirement benefit, reentitled to a disability benefit, or died, the PIA will equal the greater of: (1) The previous disability PIA increased by any intervening automatic and *ad hoc* benefit increases, (2) the minimum benefit, or (3) the special minimum benefit. The effect of this subparagraph is to provide for conversions from the disability to the retirement rolls at age 65 and to avoid providing a new, later, indexing year (or a wage-indexing computation, if the previous computation was made under the law in effect prior to 1978) in cases where an individual has been off the benefit rolls for only a short time before becoming reentitled to benefits.

Subparagraph (C) of the new section 215(a)(2) provides that when a PIA is computed after a previous disability entitlement has terminated, the PIA can be no lower than the disability PIA that was most recently determined (including automatic benefit increases up to the month of termination).

Paragraph (3) of the new section 215(a) specifies the (prospective) applicability of the new PIA computation method provided in paragraph (1) of the new section 215(a).

Subparagraph (A) of the new section 215(a)(3) specifies that the new computations provided in the paragraph (1) of the new section 215(a), except for the special minimum benefit computation, are applicable only to workers who had not attained age 62 prior to January 1979 and who became eligible for old-age or disability insurance benefits or die in or after January 1979. It also provides certain exceptions by reference to paragraph (4) (which relates to certain previously disabled workers and to the transitional provision).

Subparagraph (B) of the new section 215(a)(3) provides that unless fewer than 12 months have elapsed since the termination of a prior period of disability, a person will be deemed "eligible" (1) for old-age insurance benefits as of the month in which he attains age 62, or (2) for disability insurance benefits as of the month the period of disability began as provided under section 216(i)(2)(C) of the Act. (As specified in paragraph (2), a person who had a prior period of disability which terminated within 12 months will be deemed eligible as of the month the prior period of disability began.)

Paragraph (4) of the new section 215(a) excludes certain workers disabled before 1979 from the new PIA computation provisions (except those relating to the special minimum benefit) and contains transitional provisions protecting benefit amounts for workers reaching age 62 after 1978 and before 1989 (the transitional "guarantee").

Subparagraph (A) of the new section 215(a)(4) excludes from the new computations, (except for the special minimum benefit computation provided in subparagraph (C)(i)(II) a worker disabled before 1979, unless at least 12 months elapse after the termination of the prior period of disability and before the month he attains age 62, becomes disabled again, or dies.

Transitional provision

Subparagraph (B) contains the transitional provisions and provides that the new computations (except for the special minimum computation) will not apply to a worker who otherwise would qualify for those computations if the present law PIA computed under subsections 215(a) or (d) as in effect in December 1978 is greater.

The transitional provisions apply to workers who reach age 62 after 1978 and before 1989. They also will apply to a small number of workers who have an onset of disability, or die after 1978 if their benefit computation includes earnings after 1936 and before 1951. In determining whether the present-law benefit is greater, the benefit table as in effect in December 1978 will apply with no cost-of-living increases added to the benefit after 1978 and before the year the worker reaches age 62, becomes disabled, or dies as provided in subsection (i)(2)(A)(iii). Also, in such cases, earnings beginning with the year of age 62, disability onset or death will be excluded in computing the average monthly wage on which the benefits are based.

New section 215(a)(5) provides that in computing PIA's after December 1978 for workers who reach age 62, become disabled, or die before 1979 and therefore do not qualify for the new benefit formula or the transitional provisions, the provisions for determining the PIA in effect in December 1978 will apply except that effective for January 1979, the dollar amount used to compute a special minimum benefit will be $11.50. Also, for years after 1978, the PIA's and maximum family benefits for such workers will be increased by general ad hoc benefit increases and by automatic benefit increases (as provided by subsection (i)).

Computation of average indexed monthly earnings (AIME)

Section 201(b) of the bill provides a new section 215(b) of the Social Security Act for computing average indexed monthly earnings. The method of computing average earnings is generally the same as that used under present law except that indexed, rather than actual earnings, are used. New section 215(b)(1) provides that an individual's average indexed monthly under subsection (a)(1)(B)) wages and self-employment income in his benefit computation years (as determined under paragraph (2)) by the number of months in those years.

New section 215(b)(2)(A) provides that the number of worker's benefit computation years—the number of years used in computing AIME—equals the number of elapsed years minus 5, but in no case can the number of such years be less than 2.

Clause (i) of section 215(b)(2)(B) defines benefit computation years as the computation base years that are equal to the number of elapsed years and in which the total of indexed wages and self-employment income is the highest.

Clause (ii) defines computation base years as years after 1950 and up to: (1) The year the first month of entitlement to old-age insurance benefits occurred or (2) if the worker died without becoming entitled to a benefit the year after the year of death. Years wholly within a period of disability are excluded from computation base years.

Clause (iii) defines elapsed years as the number of years after 1950, or age 21, if later, and up to the year of death or age 62 (but not less than 5 if the year of age 62 is used). Any part of a year included in a period of disability is not counted as an elapsed year. This definition applies in all cases except under the special provision in section 104(j) (2) of the Social Security Amendments of 1972, which applies to men who reach age 62 in 1973 and 1974.

New section 215(b)(3)(A) provides that, except as specified in paragraph (B), the wages or self-employment income credited to each of a worker's computation base years will be indexed by multiplying the wages or self-employment income by the ratio of: (1) Average wages for the indexing year to (2) average wages for the year being indexed. The indexing year is the second year after 1976 and before the year of the worker's initial eligibility for old-age or disability insurance benefits (age 62 or onset of disability), or death, whichever is earliest. However, a year will not be counted as the year of the worker's eligibility or death if the worker was entitled to a disability insurance benefit for any of the 12 months immediately preceding the month he attained age 62, had an onset of disability or died.

For purposes of this subparagraph (as for purposes of section 215 (a)(1)(B)), average wages means the average of total annual wages (as reported to the Secretary of the Treasury) as defined in regulations of the Secretary (of HEW) and without regard to the contribution and benefit base limitation.

New section 215(b)(3)(B) provides that wages and self-employment income credited to an individual in all years that occur after the indexing year are counted in actual dollar amounts for purposes of computing AIME.

New section 215(b)(4) provides that for purposes of computing average monthly wages after 1978 under the provisions of the law in effect in December 1978 for a worker to whom the transitional guarantee provisions in subsection (a)(4) apply, computation base years include only years after 1950 (or 1936, if applicable) and up to the year of attainment of age 62, onset of disability, or death. Wages and self-employment income in years after those events cannot be used in a "guarantee" computation. As under present law, calendar years wholly within a period of disability also cannot be computation base years for purposes of a "guarantee" computation.

Benefit table applicable to workers eligible before 1979

New section 215(c) specifies that subsection (c) as in effect in December 1978 will remain in effect for workers who attain age 62, become disabled, or die before 1979. That is, the benefit table in effect in

December 1978, plus all subsequent cost-of-living increases under subsection (i) will apply to such workers.

Section 201(d) of the bill amends section 215(d) of the Social Security Act to provide a simplified method for computing the PIA's of workers age 21 after 1936 and before 1951 when wages before 1951 are included in the computations so that machine, rather than manual, procedures can be used in making such computations. The revised method of computing the PIA under new section 215(d)(1) is as follows: The average monthly wage of workers age 21 after 1936 and before 1951 is to be determined over the same period of years and in the same manner as provided under the law in effect in December 1977. However, the total wages paid to such workers prior to 1951 will for purposes of benefit computation years and computation base years be deemed to have been paid at an equal yearly rate up to $3000 a year (the maximum amount creditable before 1951) for years after age 21 and before the earlier of 1951 or the year of death; the remainder (I) if less than $3000, is deemed credited to the year preceding the year of age 21 or (II) if $3000 or more, is deemed credited in $3000 increments to the year of age 21 and to each year consecutively preceding that year with any remainder credited to the year immediately preceding the earliest year to which $3000 was credited. For purposes of this subsection, total wages may not exceed $42,000.

A new formula is provided for determining the PIA's which results in a PIA approximately equivalent to the amount that would result if actual yearly wages were used in the computation. The formula for determining the PIA is: 40 percent of the first $50 of average monthly wages (AMW) as computed under this subsection, plus 10 percent of the next $200 of AMW, increased by 1 percent for each increment year. The number of increment years used will not be less than 4 nor more than 14; the number is determined by dividing an individual's total wages before 1951 by $1650. (Under present law, an "increment" is the term used to describe the 1-percent increase in the primary insurance benefit that is given for each year before 1951 in which the worker was paid $200 or more; the maximum possible is 14—the number of years in the period 1937–50.)

Section 201(d) (3) of the bill amends section 215(d) (3) of the Act to delete the requirement that when wages prior to 1951 are included in computing the AMW of an individual who attains age 21 after 1936 and prior to 1951, the present law computation provisions in effect before the Social Security Amendments of 1967 must be used.

Section 201(d)(4) of the bill amends section 215(d) of the Act to add a new paragraph 4 which provides that when wages prior to 1951 are included in the computation, the present-law simplified method for computing PIA's of workers age 22 in or before 1937 remains in effect for workers who reach age 62, become disabled, or die before 1978.

References to average indexed monthly earnings

Section 201(e) of the bill amends section 215(e) of the Act, which specifies the maximum amounts of covered wages and self-employment income that can be used for purposes of computing PIA's to refer to AIME in addition to AMW, where appropriate.

Recomputations

Section 201(f) of the bill provides a new section 215(f)(2) for recomputing PIA's. The provisions for recomputing PIA's are largely the same as those in present law.

New section 215(f)(2)(A) provides that the Secretary at times prescribed in regulations, will recompute the PIA's of individuals who have covered wages or self-employment income after 1978 and who are entitled to an old-age or disability insurance benefit.

New section 215(f)(2)(B) provides that for recomputations of PIA's based on AIME, the benefit formula applied will be the one used in computing the worker's initial PIA (or for those to whom the transitional provisions apply as described in subsection (a)(4)(B)), the one that would have been used in computing the initial PIA if the "guarantee" PIA had not been higher.

New section 215(f)(2)(C) provides that as under present law, the number of computation base years are expanded to include years of additional earnings.

New section 215(f)(2)(D) provides that as under present law, a recomputation to take account of a year of additional earnings will be effective with January of the following year, or in a death case, with the month of death.

Section 201(f)(2) of the bill repeals section 215(f)(3) of the Act since it is obsolete. Paragraph (3) provides for recomputing PIA's for workers who had self-employment income in 1952 and applied for benefits or died prior to 1961.

New section 215(f)(4) provides that a recomputation will be effective only if it results in an increase in the PIA of at least $1. Section 201(f)(4) of the bill adds new paragraphs (7) and (8) to section 215(f) of the Act. New paragraph (7) provides that present law recomputation provisions will continue to apply for workers who become eligible for old-age benefits, have an onset of disability, or die before 1978. However, for an individual whose PIA is computed under the transitional provisions, earnings in and after the year of attainment of age 62 or onset of disability, or death cannot be used for purposes of recomputing the "guarantee" PIA.

New paragraph (8) provides that special minimum PIA's that were computed for beneficiaries under the law in effect prior to January 1979 will be recomputed to take account of the increase from $9 to $11.50 in the dollar amount. The recomputation will be effective beginning January 1979.

Cost-of-living increases in benefits

Section 201(g)(1) of the bill amends section 215(i)(2)(A)(ii) to specify that an automatic benefit increase effective for June of a year in which the Secretary determines that a cost-of-living computation quarter, which triggers such an increase, has occurred will apply to: (1) The benefits of those entitled to special payments under sections 227 and 228; (2) the PIA's on which beneficiaries are entitled including the frozen minimum PIA's and special minimum PIA's; and (3) maximum family benefits at the same time as the PIA's on which they are based, where a PIA was computed under the law in effect in December 1978 will be increased at the same time as the PIA's except as provided in new paragraphs 6 and 7 of section 203.

As under present law, the increase in the Consumer Price Index (CPI) measured from the last cost-of-living computation quarter to the current one (or from the last quarter in which an *ad hoc* increase became effective) and rounded to the nearest .1 of 1 percent will be applied to the benefits, PIA's, and family maximums listed above. The increased PIA's will be rounded to the next higher $.10 if not an even $.10. For beneficiaries getting special minimum benefits, the PIA's on which the special minimum benefits are based will be increased. The increase will be determined from the revised range of special minimum PIA's published by the Secretary.

Section 201(g)(2) of the bill amends section 215(i)(2)(A) of the Act by adding a new clause to make the automatic benefit increases in a year applicable to PIA's computed or recomputed in that year, regardless of when entitlement began in that year. However, the increases would be effective only for benefits payable for months after May of that year.

Section 201(g)(3) of the bill amends section 215(i)(2)(D) of the Act to provide that when the Secretary publishes the amount of an automatic cost-of-living benefit increase in the Federal Register, he must also publish the range of increased special minimum PIA's possible and corresponding family maximums for the next year. The effect of this provision is that the $11.50 dollar amount for computing special minimum PIA's will not be increased to take account of increases in the cost of living. Instead the range of PIA's possible based on the $11.50 dollar amount will be revised whenever an automatic benefit increase is effective. Each revised range of special minimum PIA's will apply to both current and future beneficiaries.

Section 201(g)(4) amends section 215(i) by adding a new paragraph (4) that provides that the automatic adjustment of benefit provisions in effect prior to 1979 shall continue to apply for workers who became eligible for old-age insurance benefits, have an onset of disability, or die before 1979 and requires that the Secretary publish the revised benefit tables for that purpose. The revised tables will not apply to those who became eligible for old-age insurance benefits, have an onset of disability, or die after 1978.

For people whose benefits are computed under the law in effect in December 1978 because the transitional provisions apply, the cost-of-living increases will not apply after 1978 and before they attain age 62, have an onset of disability or die (as provided in clause I of subsection (a)(4)(B)).

Maximum family benefits

Section 202 of the bill restates section 203(a) of the Social Security Act with changes to take account of the new system for computing PIA's based on wage-indexed earnings.

Paragraphs (1) and (2) of new section 203(a) provides for a formula for determining maximum family benefits. For workers who became eligible for old-age insurance benefits, have an onset of disability, or die in 1979, the formula for determining the maximum family benefit is:

150 percent of the first $230 of PIA, plus
272 percent PIA over $230 through $332, plus
134 percent of PIA over $332 through $433, plus
175 percent of PIA over $433.

The resulting amounts will be rounded to the next higher $.10 if not an even multiple of $.10.

For workers who become eligible for old-age insurance benefits, have an onset of disability, or die in years after 1979, the dollar amounts in the formula will be increased to take account of increases in wages in the same way that the dollar amounts in the benefit formula in section 215(a) will be adjusted.

Subparagraph (C) of new paragraph (2) provides that by November 1 of each year after 1978, the Secretary will publish in the Federal Register the formula that will be applicable to workers who become eligible for old-age insurance benefits, have on onset of disability, or die in the following year. The formula will not apply for determining maximum family benefits for workers getting special minimum benefits.

Subparagraph (D) of new paragraph (2) provides that the formula in effect in a year will not apply to a worker who becomes eligible for a retirement or disability benefit or dies in that year if he was entitled to a disability benefit for any of the 12 months before he reached age 62, had a new onset of disability, or died. In such cases, the year of eligibility will be the year of onset of disability for the benefit the worker was entitled to during the prior 12 months.

New section 203(a)(3)(A) provides that when the family maximum provisions apply to a child entitled on the earnings of more than one insured worker, the maximum family benefit will not be less than the smaller of (1) the sum of each of the maximum family benefits (as under present law) or (2) 1.75 times the highest PIA possible in the year based on AIME equal to 1/12 of the contribution and benefit based effective in that year.

Section 203(a)(2) of the Act in effect prior to December 1978, the general saving clause for beneficiaries entitled prior to January 1971, is restated with reference changes and redesignated as section 203(a)(3)(B).

Section 203(a)(3) of the Act in effect prior to December 1978 is restated and redesignated as section 203(a)(3)(C). Also, references to "wife" are changed to "spouses" in order to take account of amendments made by title IV of the bill, which, among other changes, eliminated gender-based references in the Act and provides benefits for divorced husbands.

The new section 203(a)(4) restates that the matter following paragraph (3) of section 203(a) of the Act in effect prior to December 1978, which provides that when the total of monthly benefits are reduced for purposes of the maximum family benefit, each person's benefit, except an old-age or disability insurance benefit, will be reduced proportionately and deletes obsolete special provisions for reducing benefits of illegitimate children.

Section 203(a)(4) of the Act in effect prior to December 1978 (the "no-loss" saving clause) is redesignated as section 203(a)(5) and is made applicable to all families whose benefits are limited by the family maximum. Under present law, only families in which the worker's benefit is reduced under section 202(q) are assured that the total benefits will not be less after a benefit increase than before the increase.

The new section 203(a)(6) provides that where an individual is entitled to benefits based on the PIA's of 2 or more workers and one of the PIA's is computed under the law in effect after 1978 and the other is computed under the law in effect prior to 1979, the total family benefits will be reduced to an amount equal to 1.75 times the highest PIA possible in the month based on AIME equal to 1/12 of the contribution and benefit base effective in that year.

The new section 203(a)(7) specifies that, subject to paragraph 6, the family maximum provisions in section 203(a) applicable under the law in December 1978 will remain in effect for workers who become eligible for old-age benefits, have an onset of disability, or die before 1979; for individuals who become eligible or die after 1978, the family maximum provisions in effect after 1978 will govern unless, as specified in new paragraph (2)(D), the worker was entitled to a disability benefit for any of the 12 months prior to the month he attained age 62, had an onset of disability, or death.

Increase in delayed retirement credit

Section 203 of the bill amends section 202(w) of the Act to permit the benefits to be increased after age 65 under this section regardless of whether the individual received any benefits reduced under section 202(q) prior to age 65.

This section further amends section 202(w) to provide that for workers who become eligible for old-age insurance benefits after 1978, the delayed retirement credit will be one-fourth of 1 percent per month.

Conforming amendments

Section 204(a) of the bill amends section 202(m)(1) of the Act to provide that, as under present law, a sole-surviving dependent will get a benefit equal to an amount no less than the minimum PIA provided in subsection (a)(1)(C)(i)(I). That benefit will be automatically adjusted under section 215(i) for increases in the cost of living beginning with months after May of the year in which the insured worker died.

Section 204(b) of the bill further amends section 202(w) of the Act to conform the references to the special minimum PIA for months before 1979 and for months after 1978.

Section 204(c) of the bill amends section 217(b)(1) of the Act to provide a conforming change in that provision to limit the references to computation provisions in section 215 to mean those sections as in effect prior to 1979.

Section 204(d) of the bill amends section 224(a) of the Act to retain the use of AME rather than AIME in the determination of average current earnings for purposes of determining the workmen's compensation offset.

Section 204(e) of the bill amends section 1839(c)(3)(B) of the Act to revise the method of automatically adjusting the supplementary medical insurance premium. The premium will be adjusted by using the percentage increase in PIA's based on AIME of $900. As under present law, the percentage is determined from May 1 of the year of promulgation to the following May 1.

Section 204(f) of the bill amends section 104(j)(2) of the Social Security Amendments of 1972 to refer to the section of the law defining elapsed years as amended by this bill.

Effective date

Section 205 of the bill provides that the amendments made in title II of the bill other than section 201(d) will be effective with respect to monthly benefits and lump-sum death payments for months after 1978. The amendments made by section 201(d) (the simplified method for computing PIA's where wages prior to 1951 are included in the computation) will be effective with respect to monthly benefits of an individual who becomes eligible for an old-age disability benefit, or dies after December 1977.

TITLE III—COVERAGE UNDER THE OLD-AGE SURVIVORS AND DISABILITY INSURANCE PROGRAM

Section 301. Coverage of Federal employees

Section 301 of the bill repeals the exclusion from social security coverage of services performed in the employ of the Federal Government.

Section 301(a) of the bill amends section 210(a) of the Social Security Act to repeal paragraphs (5) and (6), which now exclude from the definition of "employment" service performed in the employ of the United States or an instrumentality of the United States which is covered by a retirement system established by United States law, and of certain other instrumentalities of the United States. It also makes the technical and conforming changes in other provisions of the Act which are necessary to reflect the repeal of this exclusion.

Section 301(b) of the bill amends section 3121 of the Internal Revenue Code of 1954 to conform to the amendment made in section 210(a) of the Act by section 301(a) of the bill.

Section 301(c) of the bill provides that these amendments will be effective with respect to service performed after December 1981.

Section 301(d)(1) of the bill provides that the Secretary, in consultation with the Civil Service Commission shall make a study on how best to coordinate the benefits of the civil service retirement system with the OASDI program to develop for Federal employees a combined program of retirement, desirability, and related benefits to assure that employees are no worse off, comparing their benefits under the combined program with the benefits they would receive under the Federal staff systems then in effect, after their coverage under the OASDI program.

Section 301(d)(2) of the bill provides that no later than January 1, 1980, the Secretary shall submit a report of the study to Congress. The report will contain a specific and detailed plan for coordination of the two systems including provisions for financing and benefits.

Section 301(e) of the bill provides that the Secretary shall carry out a study of how best to coordinate the Medicare program and the program established by the Federal Employees Health Benefits Act with the objective of developing for Federal employees a combined health insurance program to accompany the retirement and disability program developed under subsection (d). The combined health insurance program shall assure that Federal employees are no worse off under that program than they were under the Federal Employees Health Benefits Act. A report of the study shall be submitted to Congress along with the report submitted under subsection (d) (2).

Section 302. Coverage of State and local employees

Section 302(a) of the bill eliminates the provisions in present law for terminations of coverage of State and local employment.

Section 302(a) (1) of the bill amends section 218(g) of the Social Security Act to make the provisions under present law for termination of coverage under a State's agreement with the Secretary subject to a new paragraph, (4), which is added by Section 302(a) (2) of the bill.

Section 302(a) (2) of the bill adds to section 218(g) of the Act a new paragraph, (4), to provide that social security coverage under a State's agreement with the Secretary may not be terminated unless the 2 years' advance notice required under present law is given before September 14, 1977.

Section 302(b) of the bill provides compulsory coverage for employees of State and local governments with respect to services performed after December 1981.

Section 302(b) (1) of the bill repeals section 218 of the Act which provides coverage for employees of State and local governments under voluntary agreements between the States and the Secretary.

Section 302(b) (2) of the bill amends section 210(a) of the Act to remove the exclusion from the definition of "employment" of services performed by employees of a State or political subdivision and certain services performed in the employ of the District of Columbia or the Government of Guam and American Samoa.

Section 302(b) (3) of the bill amends section 3121(b) of the Internal Revenue Code to remove the exclusion from the definition of "employment" of services performed by employees of a State or political subdivision and certain services performed in the employ of the District of Columbia, or the Governments of Guam and American Samoa.

Section 302(c) of the bill amends certain provisions of the Internal Revenue Code of 1954 to provide that, for purposes of adjustments because of payment of insufficient or excess employment taxes, State and local governments and their employees will be treated the same as other nonforeign governments and their employees.

Section 302(c) (1) (A) of the bill redesignates Sections 3126 and 3127 of the Code as Sections 3127 and 3128 respectively and adds a new section 3126. The new section permits the Governor of a State and his designees to make returns and payments of social security contributions for State and local employment in the State. The new section also permits the person making a return to pay the employer's contributions without regard to the limits imposed by the contribution and benefit base. (This provision is consistent with provisions in present law with respect to employment for the Governments of Guam, American Samoa, and the District of Columbia.)

Section 302(c)(1)(B) of the bill amends the table of sections for chapter 21 of the Code to conform to the amendment made by section 302(c)(1)(A) of the bill.

Section 302(c)(2)(A) of the bill amends section 6205(a) of the Code by changing the references in paragraphs (3) and (4) from "section 3125" to "section 3216" and by redesignating those two paragraphs as paragraphs (4) and (5) respectively. This section of the bill also adds a new paragraph (3) to provide that, for purposes of adjustments because of payments of insufficient social security employer and employee contributions, railroad retirement employer and employee taxes, and employees' withheld income taxes, with respect to remuneration for employment received from a State or political subdivision or instrumentality which is wholly owned by the State, the Governor of the State and each person designated by him under section 3126 of the Code shall be treated as separate employers. (This provision is consistent with provisions in present law with respect to remuneration for employment received from the Governments of the United States, Guam, American Samoa, and the District of Columbia.)

Section 302(c)(2)(B) of the bill amends section 6413(a) of the Code to conform to the amendment made by section 302(c)(1)(A) of the bill and by redesignating paragraphs (3) and (4) as paragraphs (4) and (5) respectively. This section of the bill also adds a new paragraph (3) to provide that, for purposes of adjustments because of payment of excess social security employer and employee contributions, railroad retirement employer and employee taxes, and employees' withheld income taxes with respect to renumeration received for employment from a State or political subdivision or instrumentality which is wholly owned by the State, the Governor of the State and each person designated by him under section 3126 of the Code shall be treated like separate employers. (These provisions are consistent with the provisions in present law with respect to remuneration for employment received from the Governments of the United States, Guam, American Samoa, and the District of Columbia.)

Section 302(c)(2)(C) of the bill replaces subparagraph (B) of section 6413(c)(2) of the Code with a new subparagraph (B). (Under the present subparagraph (B), remuneration for services covered by an agreement between a State and the Secretary of Health, Education, and Welfare under section 218 of the Act is treated as covered wages and the contributions made with respect to such remuneration are treated as other social security contributions for purposes of making refunds to employees for payment of excess social security employer and employee contributions, railroad retirement taxes, and withheld employees' income tax.) The new subparagraph (B) provides that the Governor of a State and each person designated by him under section 3126 of the Code shall be treated as a separate employer for purposes of refunding to employees the excess employment taxes paid on remuneration received from a State or a subdivision or an instrumentality which is wholly owned by the State. (This provision is consistent with provisions in present law with respect to refunds of employment taxes for employees of the Governments of the United States, Guam, American Samoa, and the District of Columbia.) This section of the bill also amends subparagraphs (D), (E), and (F) of section 6413(C)(2) of the Code to conform to the amendment made by section 302(c)(1)(A) of the bill.

Section 302(c)(3) of the bill amends section 230(c) of the Act to conform to the amendment made by section 302(c)(1)(A) of the bill.

Section 302(d) of the bill makes changes to the Act to conform with the repeal of section 218 of the Act.

Section 302(d)(1) of the bill amends section 205(c)(5)(F)(iii) of the Act to provide that, after the repeal of section 218 of the Act, the social security earnings records of State and local employees can be corrected after the statute of limitations has run if assessments of the amounts due under section 218 of the Act were made within the prescribed time limits.

Section 302(d)(2) of the bill amends section 209(i) of the Act (which covers as wages sick pay to an employee over age 62) to remove the reference to section 218 of the Act.

Section 302(d)(3) of the bill amends section 210(a)(10)(B)(ii) of the Act (which makes an exception to the exclusion from covered employment of services performed by students in schools, colleges, and universities when such services are covered under an agreement between a State and the Secretary) to remove the reference to section 218 of the Act.

Section 302(d)(4) of the bill repeals section 210(k) of the Act which provides compulsory coverage for certain employees of transportation systems acquired by a State or political subdivision from private ownership.

Section 302(d)(5) of the bill amends section 211(c)(1) of the Act (which includes in the definition of a trade or business, functions performed by a State or local official compensated solely on a fee basis) to remove the reference to section 218 of the Act.

Section 302(d)(6) of the bill amends section 211(c)(2)(E) of the Act (which makes an exception to the exclusion from the definition of trade or business of service performed by an employee if the service is performed by an employee of a State or political subdivision compensated solely on a fee basis) to remove the reference to section 218 of the Act.

Section 302(e) of the bill makes changes to the Code consistent with the repeal of section 218 of the Act.

Section 302(e)(1) of the bill amends section 1402(b) of the Code (which defines self-employment income) to remove the reference to section 218 of the Act.

Section 302(e)(2) of the bill amends section 1402(c)(1) of the Code (which includes in the definition of a trade or business functions performed by a State or local official compensated solely on a fee basis) to remove the reference to section 218 of the Act.

Section 302(e)(3) of the bill amends section 1402(c)(2)(E) of the Code (which makes an exception to the exclusion from the definition of trade or business of service performed by an employee of a State or local subdivision if the service is compensated solely on a fee basis) to remove the reference to section 218 of the Act.

Section 302(e)(4) of the bill amends sections 3121(b)(10)(B)(ii) of the Code (which makes an exception to the exclusion from covered employment of services performed by students in schools, colleges, and universities, when such services are covered under an agreement between a State and the Secrtary of Health, Education, and Welfare) to remove the reference to section 218 of the Act.

Section 302(e)(5) of the bill repeals section 3121(j) of the Code, which provides compulsory coverage for certain employees of transportation systems acquired by a State or political subdivision from private ownership.

Section 302(e)(6) of the bill repeals section 6511(d)(5) of the Code, which permits a refund of an overpayment of self-employment tax to a State or local employee where the overpayment is attributable to retroactive social security coverage.

Section 302(f) of the bill provides that sections 302(b) through 302(e)(5) apply with respect to services performed after December 1981, and section 302(e)(6) applies with respect to claims accruing after December 1981.

Section 303. Coverage of employees of nonprofit organizations

Section 303(a) of the bill phases out the provisions in present law for terminations of coverage of employment for tax-exempt, nonprofit organizations described in section 501(c)(3) of the Internal Revenue Code of 1954.

Section 303(a)(1)(A) of the bill amends section 312(k)(1)(D) of the Code to provide that termination of coverage of employees of nonprofit organizations is subject to the conditions specified in the new section 3121(k)(1)(G) of the Code.

Section 303(a)(1)(B) of the bill adds a new section 312(k)(1)(G) to the Code to provide that social security coverage of employees of a nonprofit organization may not be terminated by the organization unless the 2 years' advance notice required under present law is given before September 14, 1977.

Section 303(a)(2) of the bill amends section 3121(k)(2) of the Code to provide that coverage of employees of a nonprofit organization may be terminated by the Secretary with concurrence of the Secretary of Health, Education, and Welfare only if the required 60-day notice is given before September 14, 1977.

Section 303(b) of the bill provides compulsory coverage for employees of nonprofit organizations with respect to services performed after December 1981.

Section 303(b)(1) of the bill amends section 210(a)(8) of the Social Security Act by deleting subparagraph (B), thus eliminating from the list of services excluded from the definition of "employment" those services performed in the employ of the tax-exempt, nonprofit organizations.

Section 303(b)(2) of the bill amends section 3121(b)(8) of the Code to conform to the amendment made by section 303(b)(1) of the bill.

Section 303(b)(3) of the bill repeals section 3121(k) of the Code (relating to exemption of religious, charitable, and certain other organizations).

Section 304. Crediting of certain Federal, State, and local service, and certain service for nonprofit organizations, performed prior to the effective date of coverage

Section 304 of the bill amends section 213 of the Social Security Act to add a new subsection (d). The new subsection provides quarter-of-coverage credits in the case of an individual who performed services in the employ of the United States, a State or political subdivision, or a tax-exempt nonprofit organization before coverage is provided for such services (by the repeal of paragraphs (5) and (6) of section 210(a) of the Act by section 301(a) of the bill) and who also performs services in the same kind of employment and derives at least 6 quarters of coverage from such services after coverage is provided for such services under provisions of the bill. Each calendar quarter in which such an individual performed any such services before coverage was provided under provisions of the bill is treated as a quarter of coverage if it is not otherwise a quarter of coverage.

Section 305. Exclusion from coverage of certain limited partnership income

Section 305(a) of the bill amends section 211(a) of the Social Security Act by adding a new paragraph (11), which excludes from the definition of "net earnings from self-employment" the distributive share of income or loss received by a limited partner from the trade or business of a limited partnership. This exclusion does not extend to guaranteed payments as defined in section 707(c) of the Internal Revenue Code of 1954, such as salary and professional fees, received for services actually performed by the limited partner for the partnership.

Section 305(b) of the bill amends section 1402(a) of the Code by adding a new paragraph (12), which provides a change relating to definition of "net earnings from self-employment" to conform to the amendment made to section 211(a) of the Act by section 305(a) of the bill.

Section 305(c) of the bill provides that the amendment will apply with respect to taxable years beginning after December 31, 1977.

Section 306. Tax on employers of individuals who receive income from tips

Section 306(a) of the bill amends section 3121 of the Internal Revenue Code of 1954 by adding a new subsection (s), which provides that tips received by employees which are deemed to be wages under the Fair Labor Standards Act of 1938 will also be deemed to be wages under the Federal Insurance Contributions Act.

Section 306(b) of the bill amends section 3111 of the Code to impose social security taxes on employers for tips received by their employees deemed to be wages under the Fair Labor Standards Act.

Section 306(c) of the bill provides that the amendment will be effective with respect to wages paid for employment performed after December 1977.

Section 307. Revocation of exemption from coverage by clergymen

Section 307 of the bill permits clergymen who have waived social security coverage to revoke their waivers.

Section 307(a) of the bill provides that a minister or Christian Science practitioner who has received an exemption under section

1402(e) of the Internal Revenue Code from the payment of social security contributions which is in effect for the taxable year in which the bill is enacted may revoke the exemption by filing an application for revocation. Such application must be filed before the minister or Christian Science practitioner becomes entitled to social security retirement or disability benefits and no later than the due date of his Federal income tax return for his first taxable year beginning after the date of enactment of the bill. The revocation will be effective for social security benefit purposes and for self-employment tax purposes for the applicant's first taxable year ending on or after the date of enactment of the bill or beginning after that date (whichever is specified in the application) and for all succeeding taxable years. An individual whose exemption is revoked may not again file for an exemption. An application which is filed on or after the due date of the applicant's first taxable year ending on or after the date of enactment of the bill and which is effective for that taxable year must be accompanied by payment of the self-employment taxes due on the self-employment income derived in that taxable year.

Section 307(b) of the bill provides that the revocation provided in subsection 307(a) will apply (to the extent specified in subsection 307(a)) to services performed in taxable years ending on or after the date of the enactment and for social security cash benefits payable for months in or after the calendar year in which the application for revocation is filed.

Section 308. International agreement with respect to social security benefits

Section 308(a) provides that title II of the Social Security Act is amended by adding a new section 233 entitled "International Agreements."

Subsection (a) of the new section 233 authorizes the President to enter into agreements establishing totalization arrangements between the social security systems of the United States and of any foreign country. The purpose of such an agreement is to permit each country to establish entitlement to old-age, survivors and disability benefits and to benefits derived therefrom on the basis of an individual's credits in both countries, and in such cases to permit the establishment of special benefit amounts.

Subsection (b)(1) of the new section 233 defines "social security system" with respect to a foreign country as a social insurance or pension system which is of general application in the country and which pays periodic benefits (or the actuarial equivalent thereof) on account of old-age, death, or disability.

Subsection (b)(2) of the new section 233 defines the term "period of coverage" as a period of payment of contributions of a period of earnings based on wages for employment or on self-employment income, or any similar period recognized as equivalent under the U.S. social security system or that of the country party to an agreement entered into under the new section 233 of the Act.

Subsection (c)(1) of the new section 233 prescribes certain provisions that must be contained in any agreement.

Subsection (c)(1)(A) requires that an agreement contain a provision for combining periods of coverage under the Act with periods of coverage under the foreign social security system for purposes of determining entitlement to and the amount of benefits under the Act. Subparagraph (A) also requires that an individual have at least 6 quarters of coverage under the Act before his periods of foreign coverage can be combined with his periods of coverage under the Act.

Subsection (c)(1)(B)(i) requires that an agreement contain provisions for the elimination of dual coverage. United clause (i), an agreement must provide that employment or self-employment (or service recognized as equivalent under the Act or the social security system of the foreign country party to the agreement) shall, on or after the effective date of an agreement, result in a period of coverage under the Act or under the foreign system, but not under both.

Clause (ii) of subsection (c)(1)(B) requires than an agreement contain a provision setting forth the methods for determining under which system the service shall result in a period of coverage. Under this clause, a worker with a permanent connection with one system is covered by existing law under the other system, an agreement could provide that coverage be under the system with which the worker has the permanent connection. Further, where the work of a national of one country for a national of the other country now is not covered under any system [escapes coverage altogether], an agreement could cover him under one of the two systems.

Subsection (c)(1)(C) requires that an agreement contain a provision for payment of partial benefits under the Act where entitlement is acquired on the basis of combined periods of coverage under title II and under the foreign system. The benefit payable under the Act will be based on the proportion of the individual's periods of coverage completed under the Act.

Subsection (c)(2) describes two types of provisions that may be be included in an agreement. Subparagraph (A) permits an agreement to make an exception to the existing alien non-payment provisions (section 202(t) of the Act) by permitting payment of benefits to any individual residing in the other country who qualifies for a benefit under the Act without recourse to an agreement or for a benefit under an agreement.

Subsection (c)(2)(B) permits an agreement to provide that if a resident of the United States receives benefits under an agreement both from the United States and from the other country party to the agreement, and the total amount of the two benefits is less than the minimum for which he would qualify under the U.S. system if all his periods of coverage had been covered under the U.S. system, the United States will supplement the amount to raise it to the minimum benefit for which he would have qualified. (This minimum would be the amount based on the lowest figure in the table in section 215(a) of the Act, but for persons becoming eligible after 1978, the amount would be frozen at the December 1978 level.)

Subsection (c)(3) of the new section 233 provides that an individual who qualifies for a cash benefit under the Act only by combining quarters of coverage under the Act with periods of coverage under a foreign system will not thereby become entitled to benefits under section 226 of the Act (Part A of Medicare).

Subsection (c)(4) of the new section 233 permits an agreement to contain other provisions not inconsistent with section 233.

Subsection (d) of the new section 233 authorizes the Secretary to make rules and regulations and to establish reasonable and necessary procedures to carry out an agreement.

Subsection (e)(1) of the new section 233 provides for oversight of agreements by Congress by providing that any agreement entered into must be transmitted to Congress by the President.

Subsection (e)(2) provides that an agreement cannot go into effect until 90 days after it has been transmitted to the Congress. (If the Congress concurs in the proposed agreement, no action by the Congress will be necessary. If the Congress disapproves of the proposed agreement, or wishes to alter any of its provisions, it will be necessary to enact a statute to that effect.)

Section 308(b)(4) of the bill provides that where an agreement is in ternal Revenue Code of 1954 necessary to implement subsection (c)(1)(B)(i) of the new section 233 which provides for the elimination of dual coverage and the designation of which system will cover the work of an individual. Amendments are made by adding new subsections (c) to section 1401 (self-employment tax), section 3101 (employee FICA tax) and section 3111 (employer FICA tax) of the Code. Each of the new subsections provides for an exemption from the respective taxes to the extent that the self-employment income or wages involved are taxed under the social security system of the foreign country.

Section 308(b)(3) of the bill amends section 6051(a) of the Code (relating to receipts for employees (Forms W-2) which employers must furnish after the close of each calendar year) by adding a new sentence at the end of section 6051(a). The new sentence provides that wages exempted from the taxes imposed by sections 3101 (employee FICA tax) and section 3111 (employer FICA tax) of the Code pursuant to section 3101(c) or section 3111(c) of the Code as added by section 308(b)(2) of the bill shall not be included in the total amount of wages as defined in section 3121(a) of the Code (FICA wages) for purposes of the W-2. (This provision is intended to avoid the considerable administrative problems for the Social Security Administration and the Internal Revenue Service which would occur if wages exempted from FICA taxes under a totalization agreement were required to be included in the total amount of FICA wages paid as shown on the Form W-2.)

Section 308 (b)(1) and (2) of the bill make amendments to the In- effect between the United States and another country, an individual may not claim an income tax deduction or credit for the payment of the foreign social security tax.

Section 309. Validation of past Social Security coverage for Certain Illinois policemen and firemen.

Section 309(a) of the bill validates coverage of certain earnings erroneously reported to the Secretary by the State of Illinois by deeming the agreement between the Secretary and the State of Illinois providing coverage for State and local employees in Illinois to apply[es] to all services performed prior to December 31, 1977, by any individual employed by the State of Illinois or by a political subdivision in a policeman's or fireman's position covered by the Illinois Municipal Retirement Fund. The validation would apply only for those services for which the State of Illinois has paid to the Secretary of the Treasury the sums due for such services under section 218(e)(1)(A) of the Act (amounts equivalent to social security employer and employee contributions) and has not received a refund or has received a refund but repays the refund to the Secretary of the Treasury within 90 days after the date of enactment of the bill.

Section 309(b) provides that the validation of coverage authorized by subsection (a) shall not apply with respect to services performed by individuals employed by any political subdivision which indicates in a manner and within a period to be prescribed by the Secretary that it does not wish the validation to apply with respect to those services.

Section 310. Coverage for policemen and firemen in Mississippi

Section 310 of the bill amends section 218(p)(1) of the Social Security Act to add the State of Mississippi to the list of States specifically named in the law which may modify their section 218 agreements to provide coverage under the social security program for policemen and firemen who are in positions under a State or local retirement system.

The provision would be effective upon enactment but coverage permitted by the provision would be effective on whatever date is specified by the State of Mississippi in the modification of its agreement, but could not be earlier than the beginning of the fifth year before the year in which the coverage is arranged.

Section 311. Coverage under divided retirement system for State and local employees in New Jersey

Section 311 of the bill amends section 218(d)(6)(C) of the Social Security Act to add the State of New Jersey to the list of States specifically named in the law which may modify their section 218 agreements to divide a retirement system to provide coverage under the social security program for those current retirement system members who want coverage and for all future employees.

The provision would be effective upon enactment but the effective date of coverage permitted pursuant to the provision would be whatever date is specified by the State of New Jersey in the modification of its agreement, but could not be earlier than the beginning of the fifth year before the year in which the coverage is arranged.

Section 312. Coverage of service under Wisconsin retirement system

Section 312 of the bill amends section 218(m)(1) of the Social Security Act by adding "or any successor system" after "the Wisconsin Retirement Fund". Under this change, the special provisions that apply to the Wisconsin Retirement Fund would apply to any successor to that fund.

This section would be effective upon enactment.

Section 313. Conforming amendments

Section 313(a) of the bill redesignates paragraphs (8) through (20) in section 210(a) of the Social Security Act as paragraphs (5) through (17) respectively and makes conforming changes in references cited in sections 205(o), 210(b), and 211(c)(2) of the Act.

Section 313(b) of the bill redesignates paragraphs (8) through (20) in section 3121(b) of the Internal Revenue Code of 1954 as paragraphs (5) through (17) respectively and makes conforming changes in references cited in sections 1402, 3121, and 3124 of the Code.

Section 313(c) of the bill makes a conforming change in a reference cited in section 18(2) of the Railroad Retirement Act of 1974 to reflect the renumbering of paragraphs in section 210(a) of the Act by section 307(a) of the bill.

Section 313(d) of the bill provides that these amendments will be effective with respect to service performed after December 1981.

TITLE IV—ELIMINATION OF GENDER-BASED DISTINCTIONS UNDER THE OLD-AGE SURVIVORS AND DISABILITY PROGRAM

Part A—Equalization of Treatment of Men and Women Under the Program

Section 401. Divorced husbands

Section 401 of the bill provides benefits based on a retired, disabled, or deceased woman's social security earnings record for a divorced husband or surviving divorced husband on the same basis as benefits are now provided for women in like circumstances. (Section 416 of the bill will later shorten the duration-of-marriage requirement for divorced men and women.)

Section 401(a)(1) of the bill amends section 202(c)(1) of the Act, which provides husband's insurance benefits based on a retired or disabled woman's social security earnings record, to provide benefits for the divorced husband age 62 or over of a retired or disabled worker.

Section 401(a)(2) of the bill further amends section 202(c)(1) of the Act by adding a new subparagraph (C) which provides that a divorced husband (like a divorced wife) must not be married at the time he applies for benefits in order to become entitled to benefits based on his former wife's earnings. (This provision is subsequently repealed by Section 415 of the bill.)

The section also provides that benefits for husbands and divorced husbands will be terminated in the same situations as benefits for wives and divorced wives are now terminated by adding to the provisions of present law for terminating entitlement to husband's insurance benefits. Thus, husband's benefits will also terminate (1) when a retired or disabled worker and her husband are divorced and either he has not reached age 62 or he has reached age 62 but has not been married to the worker for a period of 20 years immediately before the divorce, or (2) when a divorced husband marries a person other than the worker. (The latter provision is subsequently repealed by the provisions of section 415 of the bill.)

Section 401(a)(3) of the bill makes a conforming change in section 202(c)(3) of the Act to provide that, except as provided in section 202(q) of the Act, the amount of a divorced husband's monthly benefit will be equal to one-half the primary insurance amount of his former wife.

Section 401(a)(4) of the bill further amends section 202(c) of the Act by adding a new paragraph (4) to provide that marriage to certain social security beneficiaries (women receiving benefits as an adult disabled since childhood, or a divorced wife, widow, mother, or parent) will not terminate benefits for divorced husbands, as is now the case for divorced wives. (This provision will be obviated by the provisions of section 415 of this bill.)

Section 401(a)(5) of the bill further amends section 202(c) of the Act to make a conforming change to take account of the redesignation (in section 401(a)(2)) of subparagraph (C) of section 202(c)(1) as subparagraph (D).

Section 401(a)(6) of the bill amends section 202(b)(3)(A) of the Act, which allows continuation of benefits for divorced wives who marry certain other social security beneficiaries, to provide that benefits for a divorced wife will not be terminated because of marriage to a person receiving benefits as a divorced husband. (These provisions will be obviated by the provisions of section 415 of the bill.)

Section 401(a)(7) of the bill makes a conforming change in section 202(c)(1)(E) of the Act, as redesignated by section 401(a)(2) of the bill.

Section 401(b)(1) of the bill amends section 202(f)(1) of the Act, which provides widower's insurance benefits based on a deceased woman's social security earnings record, to provide widower's insurance benefits for the surviving divorced husband, age 60 or over, of a deceased worker.

Section 401(b) (2), (3), and (4) of the bill make conforming changes in section 202(f) (widower's insurance benefits) of the Act to make reference to a deceased former spouse as well as a deceased spouse.

Section 401(b)(5) further amends section 202(f)(4) to make a conforming reference to the marriage rather than remarriage of a surviving divorced husband and to refer to a surviving divorced husband's entitlement to benefits as well as a widower's entitlement.

Sections 401(b) (6), (7), and (8) of the bill amend sections 202(e)(3)(A), 202(g)(3)(A), and 202(h)(4)(A) of the Act respectively which relate to continuation of benefits for widows, mothers and parents, respectively, who marry certain other social security beneficiaries to provide that their benefits will not be terminated because of marriage to a person receiving benefits as a divorced husband. These sections of the Act will be repealed effective January 1, 1979 by section 415 of this bill which eliminates marriage or remarriage as a factor terminating or reducing benefits.

Section 401(c)(1) of the bill amends section 216(d) of the Act to provide definitions of "divorced husband" and "surviving divorced husband" as a man divorced from an individual (or an individual who has died) but only if he was married to such individual for 20 years immediately before the divorce. The definition and duration-of-marriage requirement are equivalent to the current definition of and requirement for a divorced wife and surviving divorced wife in Section 216(d). The duration-of-marriage requirement for divorced spouses will be reduced from 20 years to 5 years effective January 1, 1979, by Section 416 of this bill.

Section 401(c)(2) of the bill amends the heading of section 216(d) of the Act by changing it from "Divorced Wives; Divorce" to "Divorced Spouses; Divorce".

Section 401(d)(1) of the bill amends section 205(b) of the Act, which relates to the procedural rights of individuals applying for benefits, to make a conforming change adding divorced husbands and surviving divorced husbands to the list of individuals who can request a hearing.

Section 401(d)(2) of the bill amends section 205(c)(1)(C) of the Act to make a conforming change by including a surviving divorced husband in the definition of a "survivor".

Section 402. Remarriage of surviving spouse before age 60

Section 402 of the bill amends section 202(f)(1)(A) of the Act to replace the existing requirement for entitlement to widower's insurance benefits that a widower must not have remarried before age 60 with the requirement that he not be married at the time he applies for such benefits, as is now the case for widows. (Section 202(f)(1)(A) as amended by this section would be deleted by section 415(d) of the bill which provides that marriage or remarriage will not bar entitlement to widower's benefits).

Section 403. Illegitimate children

Section 403 of the bill provides that an illegitimate child's status for purposes of entitlement to children's insurance benefits will be determined with respect to the child's mother in the same way as it is now determined with respect to the child's father. The section also amends the Social Security Act to conform to a 1974 Supreme Court decision in *Jimenez* v. *Weinberger*, which provided that certain illegitimate children could get benefits based on a disabled worker's earnings if the relationship and/or living with or support requirements in the statute are met at the time the child applies for benefits instead of before the worker becomes disabled, and makes a similar change with respect to children of retired workers (which were not covered by the Court's decision).

Section 403(a) of the bill amends section 216(h)(3) of the Act to provide that, as in the case of a man under present law, a woman's illegitimate child who cannot inherit from her under applicable State interstate property law and who, as a result, is not considered to be her child for social security benefit purposes, and cannot be deemed to be her child for such purposes under other provisions of such section 216(h)(3) (which are currently the same for men and women) will nevertheless be deemed to be her child for social security benefit purposes if the woman has been decreed by a court to be the child's mother, or, alternatively, the woman is shown by evidence satisfactory to the Secretary of Health, Education, and Welfare to be the child's mother and was living with or contributing to the child's support at the time the child applies for benefits.

Section 403(b) of the bill amends section 215(h)(3)(A)(i) of the Act (to parallel the Supreme Court decision in *Jimenez* v. *Weinberger*) to repeal the time requirement in present law that, for purposes of child's insurance benefits for an illegitimate child who cannot inherit from his parent under applicable State interstate property law, a retired worker's acknowledgement or a court decree that the child i his son or daughter or a court order of support must be made not les than one year before the worker became entitled to old-age insuranc benefits or reached age 65.

Section 403(c) of the bill amends section 216(h)(3)(A)(ii) of th Act (to parallel the Supreme Court decision in *Jimenez* v. *Weinberger*) to replace the present requirement that a retired worker who is show by evidence satisfactory to the Secretary to be the parent of an illegitimate child who cannot inherit from his parent under applicable Stat interstate property law was living with or contributing to the child' support at the time the worker became entitled to old-age insuranc benefits or reached age 65, with a requirement that such living with o support requirement be met at the time the child applies for benefits

Section 403(d) of the bill amends section 216(h)(3)(B)(i) of th Act (to conform to the Supreme Court decision in *Jimenez* v. *Weinberger*) to repeal the time requirement in present law that, for purpose of child's insurance benefits for an illegitimate child who cannot inher from his parent under applicable State interstate property law, a disabled worker's acknowledgement or a court decree that the child is hi son or daughter or a court order of support must be made before th worker's most recent period of disability began.

Section 403(e) of the bill amends section 216(h)(3)(B)(ii) of th Act (to conform to the Supreme Court decision in *Jimenez* v. *Weinberger*) to replace the present requirement that a disabled worker wh is shown by evidence satisfactory to the Secretary to be the parent of a illegitimate child who cannot inherit from his parent under applicabl State interstate property law was living with or contributing to th child's support at the time the worker's most recent period of disabilit began, with a requirement that such living with or support requirement be met at the time the child applies for benefits.

Section 404. Transitional insured status

Section 404 of the bill amends section 227 of the Social Security Ac which provides benefits for certain people who do not meet the regular insured status requirements to provide benefits for husbands an widowers (where comparable benefits are paid to wives and widow under present law).

Section 404(a) of the bill amends section 227(a) of the Socia Security Act to provide for the payment of husbands' benefits unde section 227.

Section 404(b) of the bill amends section 227(b) and 227(c) of th Social Security Act to provide for the payments of widowers' benefits under section 227.

Section 404(c) of the bill amends section 216 of the Social Securit Act by adding a new section 216(a). (The previous section 216(a) defining retirement age, was repealed in 1961.) The new section 216(a would define "spouse" as a wife or husband as defined in subsectio 216 (b) or (f), respectively, and "surviving spouse" as a widow o widower as defined in subsection 216 (c) or (g), respectively.

Section 405. Equalization of benefits under section 228

Section 405 of the bill amends section 228 of the Act, which provide special payments to certain uninsured individuals, to provide th each member of an eligible couple will get an equal payment (rather than, as under present law, a larger amount for the man and half that amount for his wife).

Section 405(a) of the bill amends section 228(b)(2) of the Social Security Act to provide that where a husband and wife are both receiving benefits under section 228 both of them will receive the same amount, the greater of $48.30 or $48.30 increased under the automatic provisions. ($48.30 is half the amount of the payment for a couple under the last *ad hoc* benefit increase, enacted in 1973, and effective June 1974. This amount increased by the automatic cost of living increases (8 percent in 1975, 6.4 percent in 1976, and 5.9 percent this year) would now be $58.90 and subject to future automatic increases).

Section 405(b) of the bill amends section 228(c)(3) of the Social Security Act to provide that when both spouses are receiving benefits under this section and one spouse is also receiving a governmental pension, the benefit of the other spouse will be reduced by the amount that the governmental pension exceeds $48.30 or $48.30 increased under the automatic provision.

Section 405(c) of the bill authorizes the Secretary to increase the $48.30 figure for those who get benefits under section 228 as amended by the benefit increases that have occured since 1974.

Section 406. Father's insurance benefits

Section 406 of the bill provides benefits based on a retired, disabled, or deceased woman's social security earnings record for a husband, divorced husband, widower, or surviving divorced father caring for a minor or disabled child beneficiary on the same basis as benefits are provided for women in like circumstances.

Section 406(a) of the bill amends section 202(g) of the Act, which provides mother's insurance benefits based on a deceased worker's social security earnings record for a widow or surviving divorced mother caring for a minor or disabled child beneficiary, by changing the words in the present section that refer only to women—for example, widow—to words that refer to either men or women—example, surviving spouse—so as to provide benefits for a widower as well as a widow, and a surviving divorced father as well as a surviving divorced mother, on the same basis as for women.

Section 406(b) of the bill amends the heading of section 202(g) of the Act by changing it from "Mother's Insurance Benefits" to "Mother's and Father's Insurance Benefits".

Section 406(c) of the bill amends section 216(d) of the Act (as amended by section 401 of the bill) to provide definitions of "surviving divorced father" and "surviving divorced parent." A surviving divorced father is defined as a man divorced from an individual who has died if (a) he is the father of her son or daughter, or (b) he legally adopted her son or daughter, or (c) she legally adopted his son or daughter while he was married to her and while the son or daughter was under age 18, or (d) he was married to her at the time both of them legally adopted a child under age 18. This definition is equivalent to that of a surviving divorced mother in section 216(d)(3) of present law. A surviving divorced parent is defined as either a surviving divorced mother or surviving divorced father.

Section 406(d) of the bill makes a conforming change in section 202(c)(1) of the Act to provide a cross reference to section 202(s) of the Act which is amended by section 411(f) of the bill. Taken together, the effect of these changes is to preclude entitlement of a man to husband's insurance benefits before age 62 where the only entitled child he has in his care is getting benefits solely on the basis of being a full-time student, as is now the case with respect to a woman.

Section 406(e) of the bill amends section 202(c)(1)(B) of the Act to provide that a retired or disabled worker's husband under age 62 who is caring for an entitled child beneficiary may qualify for husband's insurance benefits.

Section 406(f) of the bill amends section 202(c)(1) of the Act (as amended by section 401(a)(2)(C) of the bill) to provide that husband's insurance benefits will terminate when a man under age 62 is no longer caring for an entitled child beneficiary.

Section 406(g) of the bill amends section 202(f)(1)(C) of the Act to provide for automatic conversion from father's insurance benefits to widower's insurance benefits at age 65.

Section 406(h) of the bill makes a conforming change in section 202 (f)(6) of the Act with regard to the period of time during which, in the case of a widower who was previously entitled to father's benefits, the widower's disability must begin in order for him to become entitled to benefits as a disabled widower under age 60. Under present law, his disability must begin within 84 months after (1) his spouse's death or (2) the month his previous entitlement to disabled widower's benefits ended because his disability had ceased. Section 406(h) adds the 84-month period after his entitlement to father's benefits ends as an additional period of time during which a widower's disability may begin. This additional period of time is available to widows under present law.

Section 407. Effect of marriage on childhood disability beneficiary

Section 407(a) of the bill amends section 202(d)(5) of the Act to provide that the benefits of a male childhood disability beneficiary married to a childhood disability or disabled worker beneficiary would be terminated if the latter's benefits are terminated because she recovers or engages in substantial gainful work. (Present law provides for terminating the benefits of a female childhood disability beneficiary under similar circumstances.) Section 202(d)(5) of the Act would be deleted by section 415 of the bill, so that childhood disability benefits would not terminate for either men or women when the spouse's disability benefits are terminated.

Section 407(b) of the bill provides that the amendment made by section 407(a) of the bill will be effective with respect to terminations of benefits of a female beneficiary occurring after December 1977.

Section 408. Effect of marriage on other dependents' or dependent survivors' benefits

Section 408 of the bill provides for terminating the husband's, widower's, or parent's insurance benefits of a man married to a childhood disability beneficiary, if the disabled person's benefits are terminated because she recovers or engages in substantial gainful work, as is now the case for a woman receiving wife's, widow's, or parent's benefits. (Amendments made by section 415 of the bill would provide that benefits of the spouse of a childhood disability beneficiary or disabled worker beneficiary would not terminate for either men or women when the benefits of the disabled beneficiary are terminated.)

Section 408(a) of the bill amends section 202(c)(4) of the Act (added by section 401 of the bill) to provide that the husband's insurance benefits of a man who is married to a childhood disability beneficiary will be terminated if the benefits of the childhood disability beneficiary are terminated because she recovers or engages in substantial gainful work, as is now the case for a woman receiving wife's benefits.

Section 408(b) of the bill amends section 202(f)(4) of the Act to provide that the widower's insurance benefits of a man who is married to a childhood disability beneficiary will be terminated if the benefits of the childhood disability beneficiary are terminated because she recovers or engages in substantial gainful work, as is now the case for a woman receiving widow's benefits.

Section 408(c) of the bill amends section 202(h)(4) of the Act to provide that the benefits of a man receiving aged parent's benefits who is married to a childhood disability beneficiary would be terminated because she recovers or engages in substantial gainful work, as is now the case for a woman receiving parent's benefits.

Section 408(d) of the bill provides that the amendments made by sections 408 (a), (b), and (c) will be effective with respect to terminations of disability benefits occurring after December 1977.

Section 409. Treatment of self-employment income in community property states

Section 409(a) of the bill amends section 211(a)(5) of the Social Security Act and section 1402(a)(5) of the Internal Revenue Code, which relate to the treatment for social security purposes of self-employment income from a trade or business of a married couple in a community property state. Under present law, such self-employment income is credited to the husband unless the wife exercises substantially all of the management and control over the trade or business. The law would be changed to provide that such self-employment income will be credited for social security purposes to the spouse who exercises the greater management and control over the trade or business, except that such income and deductions shall be divided equally between the two spouses if each spouse exercises the same amount of management and control over the trade or business.

Section 409(b) of the bill provides that these amendments will be effective with respect to taxable years beginning after December 1977.

Section 410. Credit for certain military service

Section 410 of the bill amends section 217(f) of the Act, which gives widows and children the right to waive the right to a civil service survivor's annuity and instead to receive credit for military service prior to 1957 in determining eligibility for survivor's benefits or the amount of the benefit, to extend the same right to widowers.

Section 411. Conforming amendments

Section 411(a) of the bill amends section 202(b)(3)(A) of the Act (as amended by section 401(a)(6) of the bill), which relates to continuation of benefits for divorced wives who marry certain other social security beneficiaries, to allow a divorced wife who marries a man entitled to father's insurance benefits to continue to get benefits. (This section of the Act, which provides an exception to the general rules for terminating benefits upon marriage, will be made unnecessary and therefore repealed effective January 1, 1979, by section 415 of the bill, which eliminates marriage or remarriage as a factor terminating or reducing benefits in all cases.)

Section 411(b) of the bill amends section 202(p)(1) of the Act, which relates to extensions of the period of time for filing proof of support for good cause, by changing the reference to subparagraph (C) of section 202(c)(1) (relating to the support requirement for husband's benefits) to subparagraph (D) of such section to take account of the redesignation of such subparagraph by section 401(a)(2) of the bill. (However, the provisions of the section redesignated as 202(c)(1)(D) were rendered obsolete by the Supreme Court, which, in *Califano* v. *Abbott* and companion cases, declared unconstitutional the requirement that a man must establish that he received at least one-half of his support from his spouse in the year before she retired, became disabled, or died, in order to become entitled to husband's benefits based on her earnings record.)

Section 411(c) of the bill amends section 202(q)(3) of the Act by adding surviving divorced husbands to the categories of beneficiaries whose old-age or disability insurance benefits are reduced to take account of prior receipt of reduced survivor's benefits.

Section 411(d) of the bill amends section 202(q)(5) of the Act by adding a husband or widower getting benefits on the basis of having a minor or disabled entitled child in his care to the categories of beneficiaries whose benefits will not be actuarially reduced for any month such a beneficiary has such a child in his care.

Section 411(e)(1) of the bill amends section 202(q)(6)(A)(i) of the Act to make present-law provisions relating to certificates of election to receive actuarially reduced wife's insurance benefits, which are included in the law because it provides unreduced benefits to a wife with an entitled minor or disabled child beneficiary in her care, apply also with respect to husbands' insurance benefits, since the bill will provide unreduced benefits for a husband with an entitled minor or disabled child in his care.

Section 411(e)(2) amends subparagraph (B) of section 202(q)(7) to allow a husband or widower (like a wife or widow) who gets reduced benefits because he elected to receive benefits before he reached age 65 to later have his reduced benefits increased by adjusting the reduction period to take account of months the worker's child was in his or her care.

Section 411(f)(1) of the bill amends section 202(s)(1) of the Act to provide a reference to section 202(c)(1) of the Act (which is amended by section 406(d) of the bill to refer to subsection (s)). Taken together, the effect of these changes is to preclude entitlement of a man to husband's insurance benefits before age 62 where the only entitled child he has in his care is getting benefits solely on the basis of being a full-time student, as is now the case with respect to a woman.

Section 411(f)(2) of the bill amends section 202(s)(2) of the Act by adding a reference to section 202(c)(4) (which was added by section 401(a)(4) of the bill to provide that marriage to certain social security beneficiaries will not terminate benefits of divorced husbands). Taken together, the addition of paragraph (4) to section 202(c) and the change made by section 411(f)(2) allow continuation of the benefits of a divorced husband who marries a person age 18 or over entitled to child's insurance benefits only in cases where the child was under a disability. (This provision will be obviated by the provisions of section 415 of the bill, which, effective January 1, 1979, eliminates marriage or remarriage as a factor in terminating or reducing benefits.)

Section 411(f)(3) of the bill amends section 202(s)(3) of the Act to include references to subsection 202(c)(4), as added by section 401(a)(4) and amended by section 408(a) of the bill; and subsection 202(f)(4), as amended by sections 401(b)(5) and 408(b) of the bill.

Section 411(g) of the bill amends section 203(a)(3) of the Act by inserting references to divorced husbands under section 202(c) and surviving divorced husbands under section 202(f). This allows benefits for a divorced husband or surviving divorced husband to be paid without regard to the family maximum benefit provisions, in the same manner as they are paid to a divorced wife or surviving divorced wife under existing law.

Section 411(h) of the bill amends section 203(b) of the Act to insert a reference to father's benefits to provide that the earnings of his retired-worker spouse may result in deductions from a man's father's benefits, as is the case for mother's benefits under existing law.

Section 411(i) of the bill amends section 203(c) of the Act to authorize the Secretary to make deductions from benefits on account of failure to have a child in care to be the same for husbands and fathers as they are under existing law for wives and mothers.

Section 411(j) of the bill amends section 203(d) of the Act to authorize deductions from the benefits of a man getting benefits as a divorced husband or a widower getting father's insurance benefits who is married to a retired worker engaged in noncovered work outside the United States, where such deductions are now authorized for comparable female beneficiaries.

Section 411(k)(1) of the bill amends section 205(b) of the Act (as amended by section 401(d)(1) of the bill), which relates to the procedural rights of individuals applying for benefits, to add surviving divorced fathers to the list of individuals who can request a hearing.

Section 411(k)(2) of the bill amends section 205(c)(1)(C) of the Act (as amended by section 401(d)(2) of the bill) to include a surviving divorced father in the definition of "survivor" for purposes of the provisions of such section 205(c) relating to informing an individual or his survivor of the amounts of such individual's wages and self-employment income and the periods during which such wages were paid and such income was derived, as shown by records maintained by the Secretary.

Section 411(l) of the bill amends section 216(f) of the Act to allow a man who was entitled or potentially entitled to husband's insurance benefits based on the earnings of his former wife in the month before his marriage to another individual not to have to meet the 1-year duration-of-marriage requirement for husband's insurance benefits based on such other individual's earnings.

Section 411(m) of the bill amends section 216(g) of the Act to allow a man who was entitled or potentially entitled to husband's insurance benefits based on the earnings of his former wife in the month before his marriage to another individual not to have to meet the 1-year duration-of-marriage requirement for widower's insurance benefits based on such other individual's earnings.

Section 411(n) of the bill amends section 222(b)(1) of the Act to authorize deductions from the benefits of a surviving divorced husband under age 60 who is getting benefits based on disability if he refuses to accept rehabilitation services, as is now true for other such disabled dependents.

Section 411(o) of the bill amends section 222(b)(3) of the Act to authorize deductions from the benefits of a man getting benefits as a divorced husband based on the earnings of a disability insurance beneficiary if she refuses to accept rehabilitation services and has deductions made from her benefits (as is now true for other such dependent beneficiaries).

Section 411(p) of the bill amends section 222(b)(2) of the Act to authorize deductions from the benefits of a man entitled to father's insurance benefits who is married to a disability insurance beneficiary if she refuses to accept rehabilitation services and has deductions made from her benefits (as is now true for mother's insurance benefits).

Section 411(q) of the bill amends section 222(d)(1) of the Act by adding surviving divorced husbands to those disabled beneficiaries for whom the costs of rehabilitation services may be paid from the social security trust funds.

Section 411(r) of the bill amends section 223(d)(2) of the Act to make the definition of disability for widows, surviving divorced wives, and widowers, in present law apply to surviving divorced husbands as well.

Section 411(s) of the bill amends section 225 of the Act to extend the Secretary's authority to suspend benefits based on disability if he believes that a person is no longer under a disability, to benefits of a surviving divorced husband (as is now the case for other benefits based on disability).

Section 411(t)(1) of the bill amends sections 226(h)(3) of the Act to provide that, for purposes of entitlement to Medicare hospital insurance benefits, a person entiled to father's insurance benefits will be deemed to have filed for disabled widower's benefits on the basis of his application for hospital insurance benefits, in the same manner as persons entitled to mother's insurance benefits may now be deemed to have filed for disabled widow's benefits.

Section 411(t)(2) of the bill amends section 226(h)(3) of the Act to provide that, for purposes of determining an individual's entitlement to hospital insurance benefits under the preceding section, an individual will, upon furnishing proof of disability within 12 months after enactment, be deemed to have been entitled to widow's or widower's benefits as of the time they would have been entitled if timely application had been made.

Section 412. Effective date

Section 412 provides that the following changes in Part A of Title IV of the bill will be effective with respect to social security benefits for months after December 1977:

1. Provision of benefits for divorced husbands (including surviving divorced husbands).
2. Elimination of remarriage before age 60 as bar to entitlement to widower's benefits.
3. Equalization of definition of illegitimate child with respect to either parent.
4. Provision of benefits for husbands and widowers under transitional insured status.
5. Equalization of payments to each member of a couple under section 228 of the Act (uninsured individuals).
6. Provision of benefits for young fathers (including surviving divorced fathers) and husbands caring for child beneficiaries.
7. Provision allowing widower to waive credit for certain military service.

Part B—Effect of Marriage, Remarriage, and Divorce on Benefit Eligibility

Section 415. Elimination of marriage or remarriage as a factor terminating or reducing benefits

Section 415 of the bill eliminates marriage or remarriage as a factor which bars or terminates entitlement to dependent's or survivor's benefits or reduces the amount of such benefits.

Section 415(a)(1) of the bill amends section 202(b)(1) of the Act by deleting subparagraph (C), which requires that a divorced wife not be remarried in order to become entitled to wife's insurance benefits based on her former husband's social security earnings record, by deleting subparagraph (H), which generally terminates benefits of a divorced wife upon remarriage, and by redesignating the remaining subparagraphs.

Section 415(a)(2) of the bill further amends section 202(b) of the Act by deleting paragraph (3), which permits a divorced wife beneficiary to marry certain other specified dependent or survivor beneficiaries without having her benefits terminated by the marriage (these exceptions to the general termination provision are no longer needed since the general provision is eliminated).

Section 415(b)(1) of the bill amends section 202(c)(1) of the Act (as amended by sections 401(a)(2) and 406(f) of the bill) by deleting subparagraph (C), added by section 401(a)(2), which requires that a divorced husband not be remarried in order to become entitled to husband's insurance benefits based on his former wife's social security earnings record, by deleting subparagraph (I), also added by section 401(a)(2), which generally terminates benefits of a divorced husband upon remarriage, and by redesignating the remaining subparagraphs.

Section 415(b)(2) of the bill further amends section 202(c) of the Act (as amended by sections 401(a)(4) and 408(a) of the bill) by deleting paragraph (4), added by section 401(a)(4), which permits a divorced husband beneficiary to marry certain other specified dependent or survivor beneficiaries without having his benefits terminated by the marriage (these exceptions to the general termination provisions are no longer needed since the general provision is eliminated).

Section 415(b)(3) of the bill amends section 202(c)(2) of the Act (as amended by section 401(a)(5) of the bill) to change a reference to a redesignated subparagraph.

Section 415(c)(1) of the bill amends section 202(d)(1) of the Act by deleting from subparagraph (B) the requirement that a child be unmarried in order to become entitled to child's insurance benefits, and by deleting from subparagraph (D) the provision for generally terminating such benefits upon marriage.

Section 415(c)(2) of the bill further amends section 202(d) of the Act by deleting paragraph (5) (as amended by section 407 of the bill), which permits certain child insurance beneficiaries to marry certain other specified dependent or survivor beneficiaries without having his or her benefits terminated by the marriage (these exceptions to the general termination provision are no longer needed since the general provision is eliminated), and by redesignating the remaining paragraphs.

Section 415(d)(1) of the bill amends section 202(e)(1) of the Act by deleting subparagraph (A), which requires that a widow or surviving divorced wife not be married in order to become entitled to widow's insurance benefits based on her former husband's social security earnings record, by redesignating the remaining subparagraphs, and by changing references to the redesignated subparagraphs.

Section 415(d)(2) of the bill amends section 202(e)(2)(A) of the Act to remove a reference to a deleted paragraph.

Section 415(d)(3) of the bill further amends section 202(e) of the Act by deleting pargraph (3), which permits a widow or surviving divorced wife to marry certain other specified dependent or survivor beneficiaries without having her benefits terminated by the marriage, by deleting paragraph (4), which provides that the widow's insurance benefit for a widow who remarries at or after age 60 is one-half of the primary isurance amount of her deceased husband or former husband (these exceptions to the general termination provision are no longer needed since the general provision is eliminated), and by redesignating the remaining paragraphs.

Section 415(d)(4) of the bill amends section 202(e) of the Act by changing a reference to a redesignated subparagraph.

Section 415(d)(5) of the bill further amends section 202(e) of the Act by changing references to a redesignated subparagraph and paragraph.

Section 415(e)(1) of the bill amends section 202(f)(1) of the act (as amended by sections 401(b) and 402 of the bill) by deleting subparagraph (A), which requires that a widower or surviving divorced husband not be remarried in order to become entitled to widower's insurance benefits based on his former wife's social security earnings record, by deleting the provision for generally terminating such benefits upon remarriage, by redesignating the remaining subparagraphs, and by changing references to the redesignated subparagraphs.

Section 415(e)(2) of the bill amends section 202 (f)(2) of the Act by changing a reference to a redesignated subparagraph.

Section 415(e)(3) amends section 202(f)(3)(A) of the Act by removing a reference to a deleted paragraph.

Section 415(e)(4) of the bill further amends section 202(f) of the Act (as amended by section 401(b)(3) and 401(b)(5) of the bill) by deleting paragraph (4), which permits a widower or surviving divorced husband beneficiary to marry certain other specified dependent or survivor beneficiaries without having his benefits terminated by the marriage, by deleting paragraph (5), which provides that the benefit for a widower or surviving divorced husband who remarries at or after age 60 is one-half of the primary insurance amount of his deceased wife or former wife (these exceptions to the general termination provision are no longer needed since the general provision is eliminated), and by redesignating remaining paragraphs.

Section 415(e)(5) of the bill further amends section 202(f) of the Act by changing a reference to a redesignated subparagraph.

Section 415(e)(6) of the bill amends section 202(f) of the Act by changing references to a redesignated subparagraph and paragraph.

Section 415(f)(1) amends section 202(g)(1) of the Act (as amended by section 406(a) of the bill) by deleting subparagraph (A), which requires that a surviving spouse or surviving divorced spouse not be remarried in order to become entitled to mother's or father's insurance benefits based on his deceased spouse's or former spouse's social security earnings record, by changing a reference to a redesignated subparagraph, by deleting the provision for generally terminating mother's or father's insurance benefits upon remarriage, and by redesignated the remaining subparagraphs.

Section 415(f)(2) of the bill further amends section 202(g) of the Act by deleting paragraph (3), which permits a mother's or a father's insurance beneficiary to marry certain other specified dependent or survivor beneficiaries without having his or her benefits terminated by the marriage (these exceptions to the general provision are no longer needed since the general provision is eliminated).

Section 415(g)(1) of the bill amends section 202(h)(1) of the Act by deleting subparagraph (C), which requires that a parent not have remarried since his deceased child's death in order to become entitled to parent's insurance benefits based on his deceased child's social security earnings record, by deleting the provision for generally terminating such benefits upon remarriage, and by redesignating the remaining subparagraphs.

Section 415(g)(2) of the bill amends section 202(h)(4) of the Act (as amended by section 408(c) of the bill) by deleting paragraph (4), which permits a parent beneficiary to marry certain other specified dependent or survivor beneficiaries without having his benefits terminated by the marriage (these exceptions to the general termination provision are no longer needed since the general provision is eliminated).

Section 415(h) of the bill amends section 202(p)(1) of the Act (as amended by section 411(b) of the bill) by changing the reference to subparagraph (D) of section 202(c)(1) to subparagraph (C) of such section to take account of the redesignation of such subparagraph by section 415(b)(1) of the bill.

Section 415(i)(1) repeals section 202(s)(2) of the Act (as amended by section 411(f)(2)), which restricted that portion of sections 292 (b), (c), (d), (e), (f), (g), and (h), providing that the marriage of certain social security beneficiaries to a child's insurance beneficiary would not terminate their benefits, to cases where the child beneficiary is over age 18 and disabled (this restriction is no longer needed since the general provision is eliminated).

Section 415(i)(2) amends section 202(s)(3) of the Act (as amended by section 411(f)(3) of the bill) by deleting references to subsections 202 (b)(3), (c)(4), (d)(5), (e)(3), (f)(4), (g)(3), and (h)(4), which have been deleted by the preceding subsections of this section of the bill.

Section 416. Duration-of-marriage requirement for divorced spouses and surviving divorced spouses

Section 416(a) of the bill amends sections 216(d) (1) and (2) of the Act, which define a divorced wife and a surviving divorced wife, respectively, and sections 216(d) (4) and (5) of the Act as added by section 401 of the bill, which define a divorced husband and suriviving divorced husband, respectively, to specify that these definitions can be met if the individual was married to the worker for 5 (rather than 20) years immediately before divorce. The effect of the change is to reduce the duration-of-marriage requirement for aged divorced spouse's and aged or disabled surviving divorced spouse's benefits from 20 years to 5 years.

Sections 416 (b) and (c) of the bill amend section 202(b)(1)(F) of the Act (as redesignated by section 415 of the bill) and section 202(c)(1)(G) of the Act (as added by section 401 of the bill and redesignated by section 415 of the bill), respectively, to reduce from 20 years to 5 years the period immediately before divorce that a spouse age 62 or over getting wife's or husband's insurance benefits based on a retired worker's social security earnings record must have been married to the worker in order for their divorce not to terminate entitlement to wife's or husband's benefits.

Section 417. Effective date

Section 417(a) of the bill provides that section 415 of the bill, which eliminates marriage or remarriage as a factor which bars or terminates entitlement to or reduces the amount of dependent's or survivor's benefits, and section 416 of the bill, which reduces the duration-of-marriage requirement for divorced people, will be effective for benefits for months after December 1978, and, in the case of those who are not entitled to benefits of the type involved for December 1978, only on the basis of applications filed on or after January 1, 1979.

Section 417(b) of the bill provides that a person whose entitlement to dependent's or survivor's benefits terminated on account of such person's marriage or remarriage prior to January 1979, or on account of the termination (except by reason of death) of the benefits of his spouse as a childhood disability or disabled worker beneficiary, may become reentitled to such benefits (provided no event that would terminate such entitlement has since occurred) beginning with January 1979, or if later, with the first month after January 1979 in which he applies for such reentitlement.

Section 417(b) also provides that such reentitlement (and other resulting related entitlements) shall be treated as though the reentitlement were the person's initial entitlement.

Part C—Study

Section 421. Study of proposals to eliminate dependency and sex discrimination under the social security program

Section 421(a) of the bill directs the Secretary of Health, Education, and Welfare, in consultation with the Task Force on Sex Discrimination in the Department of Justice, to carry out, within the Department of Health, Education, and Welfare and the Social Security Administration, a detailed study of proposals to eliminate dependency as a factor in entitlement to spouse's social security benefits, and of proposals to bring about equal treatment of men and women in any and all respects under social security. In carrying out this study, the Secretary shall take into account the effects (particularly on women's entitlement to social security benefits) of such things as: changes in the nature and extent of women's labor-force participation, the increasing divorce rate, and the economic value of women's work in the home. The study shall include appropriate cost analyses.

Subsection (b) provides that the Secretary shall submit to Congress, within 6 months of enactment, a full and complete report on the study.

TITLE V—CHANGES IN EARNINGS TEST UNDER THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE PROGRAM

Section 501. Liberalization of earnings test for individuals age 65 and over

Section 501 of the bill amends section 203(f) of the Social Security Act to increase the amount of earnings a beneficiary, age 65 or over, may have in a year and still be paid full benefits for the year. (This provision would not change the exempt amount for beneficiaries under 65.) It also makes a conforming amendment in paragraph (1)(A) of section 203(h) of the Act.

Section 501(a) amends section 203(f)(8)(A) to provide that the automatic adjustment process shall apply to both the exempt amount for beneficiaries under age 65 and the new exempt amount for beneficiaries age 65 and over.

Section 501(b)(1) of the bill amends section 203(f)(8)(B) of the Act, to take account of the new subparagraph (D) added by section 501(b) of the bill.

Section 501(b)(2) of the bill amends section 203(f)(8)(B)(i) of the Act to conform with the concept of the two separate annual exempt amounts.

Section 501(b)(3) of the bill amends section 203(f)(8)(B) of the Act to conform with the concept of two separate annual exempt amounts.

Section 501(c)(1) of the bill amends section 203(f)(8) of the Act by adding new subparagraph (D) which sets the exempt amount for any beneficiary age 65 or over at $333.33 for each month of any taxable year ending after 1977 and before 1979 and at $375 for each month of any taxable year ending after 1978 and before 1980. Also section 501(c)(1) of the bill provides that the determination of the exempt amounts for years following 1978, shall take into account the exempt amount for beneficiaries age 65 and over set by section 501(b) of the bill as if the amount had been determined by the automatic adjustment process described in section 203(f)(8) of the Act.

Section 501(c)(2) of the bill provides that determination, publication and notification of the new exempt amount applicable to beneficiaries under age 65, under the automatic adjustment provisions of section 203(f)(8) of the Act shall be required in 1977 and 1978 because the exempt amount set by section 501(c)(1) of the bill applies only to beneficiaries age 65 or over. Section 501(c)(2) of the bill also provides that the annual exempt amount applicable to beneficiaries under 65, for 1978 as determined by the automatic adjustment process will go into effect despite the provisions of section 203(f)(8)(C) of the Act.

Section 501(d) of the bill amends subsections (f)(1), (f)(3), (f)(4)(B), and (h)(1)(A) of section 203 of the Act by deleting "$200 or" and inserting "the applicable exempt amount" since in all cases the amount determined by the process set forth in section 203(f)(8)(B) of the Act will be greater than $200.

Section 501(e) of the bill provides that these amendments will be effective for taxable years ending after December 1977.

Section 502.—Elimination of monthly earnings test

Section 502(a) of the bill amends Sec. 203(f)(1)(E) of the Social Security Act to eliminate the monthly measure of the retirement test.

The monthly measure will still apply in one limited situation—the year in which a person first receives social security benefits of a particular type (without having received benefits of any other type in the preceding month) which not rendering substantial services in self-employment or earning wages in excess of the exempt amount—but for all other years the annual measure only will be applied.

Section 502(b) of the bill provides that this amendment will apply with respect to monthly benefits payable for months after December 1977.

Section 503. Liberalization of test for determining deductions on account of noncovered work outside the United States

Section 503(a) of the bill amends sections 203 (c)(1), (d)(1), and (d)(2) of the Social Security Act by changing, effective with respect to months in taxable years ending after 1977 and before 1979, from 6 to 8 the number of days in a month on which a beneficiary can work in noncovered work outside the United States, without losing his benefit for that month.

Section 503(b) of the bill amends sections 203 (c)(1), (d)(1), and (d)(2) of the Act (as amended by subsection (a) of this section) by changing, effective with respect to months in taxable years ending after 1978, from 8 to 11 the number of days in a month on which a beneficiary can work in noncovered work outside the United States without losing his benefit for that month.

TITLE VI—COMBINED SOCIAL SECURITY AND INCOME TAX ANNUAL REPORTING

Part A—Amendments to Title II of the Social Security Act

Section 601. Annual crediting of quarters of coverage

Paragraphs (a)(1) and (a)(2) of section 601 of the bill amend sections 209(g)(3) and 209(j) of the Social Security Act to provide that remuneration of less than $100 in a year paid an employee by an employer for services not in the course of the employer's trade or business or for service described in section 210(j)(3)(C) of the Act (relating to home workers) will be excluded from the definition of wages. (Under present law, the remuneration is excluded from wages if it amounts to less than $50 in a quarter.) Section 601(a)(1) of the bill also amends section 210(a)(17)(A) of the Act to provide that services in the employ of an organization registered or required to register as a Communist-action organization, a Communist-front organization, or a Communist-infiltrated organization will be excluded from the definition of employment in a year in which the organization is registered or required to register as such an organization. (Under present law, such service is excluded from employment in a quarter in which the organization is required to so register.) Section 601(a)(1) of the bill also amends secton 210(f)(4)(B) of the Act to include in the definition of cooperative organization any unincorporated group of farm operators if the number of operators in a group is more than 20 at any time during a year. (Under present law, the definition applies to an unincorporated group of farm operators if the number is more than 20 during a quarter.)

Section 601(a)(3) of the bill changes the basis of the coverage exclusion of employees of certain tax-exempt organizations to the amount of wages paid in a year rather than the amount earned in a year because the annual wage reports will be reports of wages paid rather than earned.

Section 601(a)(3)(A) of the bill adds to section 209 of the Act a new subsection (p) to exclude from the definition of wages remuneration paid by an organization, exempt from income tax under section 501 of the Internal Revenue Code of 1954, in a year if the remuneration is less than $100.

Section 601(a)(3)(B) of the bill deletes section 210(a)(10)(A) of the Act (which excludes from the definition of employment services performed in a quarter in the employ of an organization exempt from income tax under section 501 of the Code if the remuneration for such service is less than $50) and redesignates section 201(a)(10)(B) of the Act as section 210(a)(10), and clauses (i) and (ii) of such section as subparagraphs (A) and (B), respectively.

Section 601(b) of the bill redesignates, effective January 1, 1978, section 212 of the Act as section 212(a), redesignates sections 212(a) and 212(b) as sections 212(a)(1) and 212(a)(2), and adds a new section 212(b).

The redesignated section 212(a)(1) of the Act provides that for a taxable year which is a calendar year beginning before 1978, self-employment income will be credited equally to each calendar quarter of the year for purposes of determining average monthly wage and quarters of coverage.

The redesignated section 212(a)(2) of the Act provides that in the case of a taxable year which is not a calendar year beginning before 1978, self-employment income will be credited equally to the calendar quarter in which such year ends and to each of the next three or fewer preceding quarters any part of which is in such year, for purposes of determining average monthly wage and quarters of coverage.

The new section 212(b)(1) of the Act provides that for a taxable year which is a calendar year or wholly within a calendar year beginning after 1977, self-employment income will be credited to such year for purposes of determining a person's average monthly wage or quarters of coverage.

The new section 212(b)(2) of the Act provides that for a taxable year which is not a calendar year beginning after 1977, self-employment income will be allocated proportionately to the two calendar years, portions of which are included within such taxable year, on the basis of the number of months in each such calendar year which are included completely within the taxable year. The calendar month in which such taxable year ends will be treated as completely within that taxable year.

Section 601(c) of the bill amends section 213(a)(2) of the Act effective January 1, 1978, by redesignating section 213(a)(2) as sections 213(a)(2)(A) and 213(a)(2)(B), and adds new sections 213(a)(2)(A)(ii), 213(a)(2)(B)(vi), and 213(a)(2)(B)(vii).

The redesignated section 213(a)(2)(A)(i) of the Act provides that, subject to the provision of subparagraph (B), for calendar years before 1978, a quarter of coverage is a quarter in which a person has been paid at least $50 (except wages for agricultural labor paid after 1954) or in which he has been credited with $100 or more in self-employment income.

The new section 213(a)(2)(A)(ii) of the Act provides that, subject to the provisions of subparagraph (B), for calendar years after 1977, a person will be credited with a quarter of coverage for each $250 of wages paid and self-employment income credited in a year, with the quarters of coverage being assigned to specific calendar quarters only if it was necessary to enable a person to meet the requirements for insured status as prescribed in subsection (a) or (b) of section 214, or for entitlement to a computation or recomputation of his primary insurance amount, or of paragraph (3) of section 216(i).

Sections 213(a)(2)(i), 213(a)(2)(ii), 213(a)(2)(iii), and 213(a)(2)(v) of the Act are redesignated by the bill as section 213(a)(2)(B)(i), 213(a)(2)(B)(ii), 213(a)(2)(B)(iii), and 213(a)(2)(B)(v) respectively, but not otherwise changed.

The redesignated section 213(a)(2)(B)(iv) of the Act as amended by the bill provides that the special rule for determining quarters of coverage for wages paid for agricultural labor will only apply to calendar years after 1954 and before 1978.

The new section 213(a(2)(B)(vi) of the Art provides that not more than one quarter of coverage may be credited to a calendar quarter.

The new section 213(a)(2)(B)(vi) of the Act provides that not more than four quarters of coverage may be credited in a calendar year after 1977. Section 601(d) of the bill provides that the amendments made by subsection (a) will apply with respect to remuneration paid and services rendered after December 31, 1977, and the amendments made by subsections (b) and (c) will be effective January 1, 1978.

Section 602. Adjustment in amount required for a quarter of coverage

Section 602(a) of the bill amends section 213(a)(2)(A)(ii) of the Social Security Act, as amended by section 601(c) of the bill, to provide that the amount of wages and self-employment income needed for a quarter of coverage for years after 1977 will be determined under section 213(e) of the Act, as added by the bill.

Section 602(b) of the bill adds to section 213 of the Act new subsections (e)(1) and (e)(2).

The new subsection 213(e)(1) provides that the amount of wages and self-employment income needed for a quarter of coverage in 1978 will be $250, and for years after 1978 the amount needed will be determined under subsection (e)(2).

The new subsection 213(e)(2) provides that beginning in 1978, and each year thereafter, the Secretary will determine and publish in the Federal Register on or before November 1 the amount of wages and self-employment income which will be required for a quarter of coverage in the following year. The amount required for a quarter of coverage will be the larger of (1) the amount already in effect, or (2) the product of the amount for 1978 ($250) and the ratio of the average total wages of all workers in the year before the year the Secretary's determination is made to the average total wages of all workers in 1976, rounded to the nearest $10. (The wage data used to determine the increase in average total wages, as defined in regulations promulgated by the Secretary, will be obtained from reports made to the Secretary of the Treasury. Forms 1040 for 1977 and 1978 will be used in the determination made in 1979, and Forms W-2 for 1978 and later years will be used in the determinations made after 1979. The data will, beginning in 1977, include the reports of wages for employment both covered and not covered under the Social Security Act, and will include wages in excess of the contribution and benefit base. For 1976, appropriate adjustments will be made in the average wage data in covered employment (the only adequate data available) to make it comparable to the broader measure used beginning with 1977.)

Section 602(c) of the bill provides that these amendments will be effective January 1, 1978.

Section 603. Technical and conforming amendments

Section 603(a)(1) of the bill makes an editorial change in section 203(f)(8)(B)(i) of the Social Security Act to clarify it.

Section 603(a)(2) of the bill amends section 203(f)(8)(B)(ii) of the Act to provide that automatic adjustments of the retirement test exempt amount will be based on increases in average yearly wages rather than on increases in wages reported for the first quarter of the year, beginning with the determination to increase the exempt amount in 1980. This corrects a defect in present law which requires the use of first quarter wage data for 1978, which will not be available under present annual reporting provisions. Under the bill, the wage data used to determine the increase in average yearly wages, as defined in regulations promulgated by the Secretary will be obtained from reports made to the Secretary of the Treasury. (Data from Forms 1040 for 1977 and 1978 will be used in determining the exempt amount for 1980, and data form W-2 for 1978 and later years will be used in determining the exempt amount for years after 1980. The data will, beginning in 1977, include the reports of wages for employment both covered and not covered under the Act, and will include wages in excess of the contribution and benefit base.)

Section 603(b) of the bill amends section 218 of the Act pertaining to voluntary agreements for coverage of State and local employees. Although the States are excluded from the change to annual wage reporting and will continue to report covered wages on a quarterly basis, the quarterly wages reported by the States will be compiled by the Social Security Administration and maintained as an annual amount for each employee. This will make it possible to apply the annual quarter-of-coverage measure as provided by the bill to State and local employees. Section 603(b) amends section 218 to make it consistent with this change.

Section 603(b)(1) of the bill amends section 218(c)(8) of the Act to provide that a State may modify its agreement to exclude services performed by election officials or election workers if the remuneration paid was less than $100 in a year. (Under present law, the services may be excluded if the remuneration is less than $50 in a calendar quarter.)

Sections 603(b)(2), 603(b)(3), and 603(b)(4) of the bill amend sections 218(q)(4)(B), 218(q)(6)(B), and 218(r)(1) respectively of the Act to make conforming changes in the rules pertaining to time limitations on assessments, credits, and refunds to take account of wages paid in a year rather than wages paid in a quarter.

Section 603(c)(1) amends section 224(a) of the Act by deleting the last sentence, so that the authority of the Secretary to estimate wages in determining the amount of reduction in benefit amounts in certain cases where the beneficiary is also receiving workmen's compensation payments will only apply to years before 1978. (Under annual reporting, a worker's total earnings will be reported on Forms W-2 and processed by the Social Security Administration; therefore, it will not be necessary to estimate the earnings in these cases.)

Section 603(c)(2) amends section 224(f)(2) of the Act, effective January 1, 1979, to provide that the periodic redetermination of the benefit reduction in cases where the worker is also entitled to workmen's compensation will be based on increases in average yearly wages rather than on increases in wages reported for the first quarter of the year. (Under present law, in redetermining the benefit reduction, a person's average current earnings are increased by the ratio of the average of the taxable wages of all persons reported to the Secretary for the first quarter of the year before the year the redetermination is made to the average of such wages for the first quarter of the year before the year the benefit reduction was first computed.) Under the bill, a person's average current earnings will be increased by the ratio of the average of the total wages reported to the Secretary of the Treasury or his delegate for the year before the year the redetermination is made to the average of such wages for 1977, or if later, the year before the year the benefit reduction was first computed. If a benefit reduction was first computed before 1978, the average current earnings will be further increased by the ratio of the average of the taxable wages reported to the Secretary for the first quarter of 1977 to the average of such wages reported for the first quarter of the year before the year the benefit reduction was first computed. The transitional provision is needed since annual wage data is not available for years before 1978.

Section 603(d) of the bill amends section 229(a) of the Act to provide that for years after 1977 a person, who was paid wages for service as a member of a uniformed service, will be deemed to have been paid $100 for each $300 of such wages to a maximum of $1,200 of deemed wages in any calendar year. (Under present law, a person receives wage credits of $300 in any calendar quarter in which he received pay for such service; the present law rule will continue to apply to calendar quarters after 1955 and before 1978.)

Section 603(e)(1) of the bill amends section 230(b) of the Act by deleting the last sentence in the matter after paragraph (2), which provides a transitional method for automatically adjusting the contribution and benefit base in accordance with increases in quarterly wages for 1978. However, quarterly wage data will not be available for 1978 since annual wages only will be reported beginning in that year.

Section 603(e)(2) of the bill makes an editorial change in section 230(b)(1) of the Act to clarify it.

Section 603(e)(3) of the bill amends section 230(b)(2) of the Act to provide that the contribution and benefit base will be automatically adjusted in accordance with increases in average yearly wages rather than with increases in wages reported for the first quarter of the year, beginning with the determination to increase the base in 1980. (Under present law, the transition from the use of quarterly wages to the use of annual wages to determine the increases in average wages will not be made until the determination to increase the base in 1981.) Under the bill, the wage data used to determine the increase in average yearly wages, defined in regulations promulgated by the Secretary, will be obtained from reports made to the Secretary of the Treasury. (Forms 1040 for 1977 and 1978 will be used in determining the base for 1980, and Forms W-2 for 1978 and later years will be used in determining the base for years after 1980. The data will, beginning in 1977, include the reports of wages for employment both covered and not covered under the Act, and will include wages in excess of the contribution and benefit base.)

Miscellaneous technical and conforming amendments

Section 603(f)(1) of the bill amends section 202(u)(1)(C) of the Act to provide that in the case of a person convicted of certain subversive activities after December 31, 1977, the court may order, in addition to all other penalties provided by law, that wages paid to the person in the year he was convicted or in any prior year be excluded in determining entitlement to social security benefits or the amount of the benefits. (Under present law, wages paid in the calendar quarter of the conviction or any prior calendar quarter may be excluded.)

Sections 603(f)(2)(A) and 603(f)(2)(B) of the bill amend section 205(c)(1 of the Act to redefine the term "period" as a year rather than a quarter, after 1977.

Section 603(f)(2)(C) of the bill amends section 205(o) of the Act which provides that railroad compensation which was remuneration for employment under the Act will be presumed, in the absence of evidence to the contrary, to have been paid in equal proportions with respect to all months in the year in which the employee rendered services, by limiting the provision to compensation for years before 1978 (prior to annual reporting). Section 603(g) of the bill provides that the amendments made by subsection (b) will apply with respect to remuneration paid after December 31, 1977; the amendments made by subsections (d) and (f)(2) will be effective January 1, 1978; and except as otherwise specifically provided, the remaining amendments made by the section will be effective January 1, 1979.

Part B—Amendments to the Internal Revenue Code of 1954

Section 611. Deduction of Tax from Wages

Section 611(a) of the bill amends section 3102(a) of the Internal Revenue Code of 1954 to provide that an employer may deduct social security taxes from the remuneration paid an employee rendering services not in the course of the employer's trade or business or services described in section 3121(d)(3)(C) of the Code even though the total remuneration paid the employee in the year by the employer is less than $100. (Under present law, an employer may deduct the taxes even though the total remuneration in a quarter is less than $50.)

Section 611(b) of the bill amends section 3102(c) of the Code, which pertains to the special rule for deducting from wages the social security tax on tips, to provide that the taxes will be deducted from wages paid and reported on a yearly basis rather than wages paid and reported on a quarterly basis.

Section 611(c) of the bill provides that the amendments will be effective with respect to remuneration paid and to tips received after December 31, 1977.

Section 612. Technical and conforming amendments

Section 612(a) of the bill amends sections 3121(a)(7)(C) and 3121(a)(10) of the Internal Revenue Code [to] of 1954 to conform to amendments made by sections 601(a)(1) and 601(a)(2) of the bill.

Section 612(b) of the bill adds a new section 3121(a)(16) to the Code to conform to the addition to the Social Security Act made by section 601(a)(3)(A) of the bill.

Section 612(c) of the bill amends section 3121(b)(10) of the Code to conform to amendments made by section 601(a)(3)(B) of the bill.

Section 612(d) of the blil amends sections 3121(b)(17)(A) and 3121(g)(4)(B) of the Code to conform to amendments made by section 601(a)(1) of the bill.

Section 612(e) of the bill provides that the amendments will be effective with respect to remuneration paid and services rendered after December 31, 1977.

Part C—Conforming Amendment to the Railroad Retirement Act of 1974

Section 621. Computation of employee annuities

Section 621(a) of the bill amends section 3(f)(1) of the Railroad Retirement Act of 1974 which provides that for purposes of computing railroad retirement annuities, wages covered under social security are assumed to have been paid in equal proportion with respect to all months in the calendar year, by limiting application of the provision to years before 1978 (before annual reporting).

Section 621(b) of the bill provides that the amendment would be effective January 1, 1978.

Section 701. Actuarial reduction of benefit increases to be applied as of time of original entitlement

Section 701(a) of the bill amends section 202(q)(4) of the Act to provide that where a worker's PIA reduced under this subsection is increased, the amount of the reduction—after any adjustment under paragraph (7) for months benefits were not payable after the entitlement month and before age 65 (62 and 65 for widows and widowers)—will be reduced, beginning with the month the PIA increase is effective, as though the increased PIA had been in effect from the first month of entitlement. This change is effective for PIA increases and for increases in benefits after the application of paragraph (7) that are payable for months after December 1977.

Section 701(b) of the bill provides that for beneficiaries entitled to benefits reduced under section 202(q) (1) and (3) prior to January 1978, each time there is an increase in primary insurance amounts the amount of reduction will be increased by the same percentage as the primary insurance amounts are increased. When a person's benefits are increased under paragraph (7) because of months in which he did not receive reduced benefits, the amount of the reduction will be decreased—

(1) for those getting old-age or spouses' benefits, by the ratio of the number of months in the adjusted reduction period to the number of months in the reduction period;

(2) for those getting widows' or widowers' benefits for the month in which they attain age 62 by the ratio of (A) the number of months in the reduction period beginning with age 62 times 19/40 of 1 percent plus the number of months in the adjusted reduction period prior to age 62, plus the number of months in the adjusted additional reduction period times 43/240 of 1 percent to (B) the number of months in the reduction period multiplied by 19/40 of 1 percent plus the number of months in the additional reduction period multiplied by 43/240 of 1 percent and

(3) for those getting widows' and widowers' insurance benefits for the month in which they attain age 65 by the ratio of (A) the number of months in the adjusted reduction period times 19/40 of 1 percent, plus the number of months in the adjusted additional reduction period times 43/240 of 1 percent to (B) the number of months in the reduction period beginning with age 62 times 19/40 of 1 percent, plus the number of months in the adjusted reduction period prior to age 62 times 19/40 of 1 percent, plus the number of months in the adjusted additional reduction period by 43/240 of 1 percent. The amount of any decrease if not a multiple of $.10 would be rounded to the next lower multiple of $.10.

Section 701(c) of the bill provides that when a person is entitled to two or more benefits and one or more of them are reduced under this subsection as amended by this Act, subsection (b) of this Act will apply separately to each reduced benefit before the application of section 202(k), which pertains to the method for offsetting benefits when a person is entitled to more than one benefit. Also, paragraph

(4) of this subsection as amended by this Act will continue to operate in conjunction with paragraph (3) of this subsection.

Section 701(d)(1) of the bill amends section 202(q)(7)(C) of the Act to provide that the reduction made in wife's or husband's benefits will be adjusted at age 65 for any months of nonentitlement to those benefits between ages 62 and 65.

Section 701(d)(2) of the bill amends section 202(q)(3)(H) of the Act to provide that a widow's insurance benefit will be reduced under paragraph (1) of this subsection if a widow becomes entitled to an old-age benefit and a widow's benefit in the same month.

TITLE VII—MISCELLANEOUS PROVISIONS

Section 702. Elimination of certain optional payment procedures under the old-age, survivors, and disability insurance program

Section 702 of the bill provides that monthly cash benefits will not be paid retroactively, with certain exceptions, for any month before the month in which the application was filed when such retroactivity would result in permanently reduced benefits.

Section 702(a)(1) amends Section 202(j) of the Social Security Act, which deals with applications for benefits, to provide that entitlement to benefits will be subject to this provision.

Section 702(a)(2) further amends Section 202(j) by adding a new subsection (4). Subsection 4(A) provides that no individual will be entitled to benefits for any month prior to the month in which he filed an application if the effect of the entitlement would be to permanently reduce his monthly benefits.

Subsection 4(B) provides several exceptions to subparagraph (A):

> 4(B)(i) exempts an individual for any month in which he or she has a dependent who is entitled to unreduced benefits based on the individual's wage record;
>
> 4(B)(ii) exempts an individual applying for benefits as a disabled surviving spouse or surviving divorced spouse, for any month before he or she attained age 60;
>
> 4(B)(iii) exempts an individual who in the year in which he files the application had excess earnings (under the retirement test) which could be charged to such prior months.

Section 702(a)(3) amends Section 226(h) of the Act, by adding a new paragraph (e), which provides that, for purposes of determining entitlement to such benefits, an individual entitled to disabled surviving spouse's, or surviving divorced spouse's benefits would also be deemed to be exempted from the limit on retroactivity.

Section 702(b) provides that the amendments made by this section would be effective with respect to applications for benefits under title II of the Social Security Act filed after December 31, 1977.

Section 703. Early mailing of benefit checks where regularly scheduled delivery day falls on Saturday, Sunday, or legal holiday

Section 703(a) of the bill adds a new section, section 708, to title VII of the Social Security Act, which deals with the administration of the programs covered by the Social Security Act.

Section 703(a) requires that, when the date of delivery for either social security or supplemental security income checks falls on a Saturday, Sunday, or legal public holiday, the checks would be delivered on the first day preceding that day which is not a Saturday, Sunday, or legal public holiday, even if delivery would be made before the end of the month for which such checks are issued.

Section 703(b) amends Sections 204 and 1631(b) of the Act, both of which deal with correct payment amounts, to provide that no attempt will be made to recover incorrect payments that occur solely because payment was made early under this provision.

Section 703(b) provides that the amendments made by this section will be effective with benefit checks regularly scheduled for delivery on or after the thirtieth day after enactment of this Act.

Section 704. Definition

Section 704 of the bill defines the term "Secretary," as used in the bill, as the Secretary of Health, Education, and Welfare, unless it is otherwise indicated by the context.

VI. OTHER MATTERS TO BE DISCUSSED UNDER THE RULES OF THE HOUSE

In compliance with clause 2(1)(2)(B) of rule XI of the Rules of the House of Representatives, the following statement is made relative to the vote by your committee on the motion to report the bill, as amended. A total of 23 votes were cast for reporting the bill, a total of 14 votes were cast against reporting the bill.

In compliance with clause 2(1)(3)(A) of rule XI of the Rules of the House of Representatives, the following statement is made relative to oversight findings by your committee. As a result of investigations conducted by the Subcommittee on Social Security, your committee concluded that it is necessary and desirable to enact legislation to ensure adequate financing of the Old Age, Survivors and Disability Insurance programs.

In compliance with clause 2(1)(3)(D) of rule XI of the Rules of the House of Representatives, your committee states that no oversight findings or recommendations have been submitted to your committee by the Committee on Government Operations with respect to the subject matter contained in the bill.

In compliance with clause 7 of rule XIII of the Rules of the House of Representatives, the following statement is made relative to the costs incurred in carrying out this bill. A complete discussion of the costs of the social security program provisions of the bill is contained in section IV of this report, which describes the financing of the amended programs. The following table sets forth the estimated additional income and outgo of the social security trust funds under present law resulting from the provisions of this bill, for fiscal years 1978 through 1983.

In compliance with clause 2(1)(4) of rule XI of the Rules of the House of Representatives, the Committee estimates that enactment of H.R. 9346 will not have a significant inflationary impact on the national economy. There are factors working in opposite directions. The first factor is that the increase in payroll taxes on the employer would likely result in higher consumer prices, to the extent that they would be passed forward to consumers in the form of higher product prices. Counteracting this effect are two opposing factors. The first would be the anti-inflationary effect of higher employee taxes which would decrease consumer demand. The second is that if trust fund outgo was allowed to exceed income by substantial margins, as is currently projected, this increased consumer income would likely result in substantial inflationary pressure. Thus on balance, the Committee believes that net inflationary pressures will be very small or negligible because attempts by firms to raise their product prices to recoup higher employer payroll taxes will be offset by reduced demand for their products.

ESTIMATED ADDITIONAL INCOME AND ADDITIONAL OUTGO OF THE OASI AND DI TRUST FUNDS, COMBINED, OVER PRESENT LAW, RESULTING FROM PROVISIONS OF THE COMMITTEE BILL, FISCAL YEARS, 1978-83

[In billions]

	Additional income	Additional outgo
Fiscal year:		
1978	$2.2	−$0.3
1979	5.9	.4
1980	8.5	.5
1981	12.3	.1
1982	24.3	−.6
1983	31.7	−1.3

Estimated additional income to the HI trust fund over present law, resulting from provisions of the committee bill, fiscal years 1978–83

	Additional income (billions)
Fiscal years:	
1978	−$1.1
1979	−1.3
1980	−1.2
1981	−0.2
1982	2.6
1983	4.2

Note: Additional outgo over present law, resulting from provisions of the committee bill, is less than $50,000,000 in any year.

Your committee's cost estimates relating to the provisions of the bill, which were furnished to the committee by the Department of Health, Education, and Welfare, constitute the best information available at this time.

In compliance with Clause 2(l)(3)(B) of Rule XI of the Rules of the House of Representatives your committee advises that H.R. 9346, as reported by your committee, involves no new or increased tax expenditures, and the new budget authority involved therein is tabulated in the report of the Congressional Budget Office, below.

In compliance with Clause 2(l)(3)(C) of Rule XI of the Rules of the House of Representatives, the cost estimate supplied your committee by the Congressional Budget Office follows:

U.S. Congress,
Congressional Budget Office,
Washington, D.C., October 12, 1977.

Hon. Al Ullman,
Chairman, Committee on Ways and Means,
U.S. House of Representatives, Washington, D.C.

Dear Mr. Chairman: Pursuant to Section 403 of the Congressional Budget Act of 1974, the Congressional Budget Office has prepared the attached cost estimate for H.R. 5383, the Social Security Financing Amendments of 1977.

Should the Committee so desire, we would be pleased to provide further details on the attached cost estimate.

Sincerely,

James Blum,
(For Alice M. Rivlin, Director.)

Congressional Budget Office, Cost Estimate

1. Bill number: H.R. 9346.
2. Bill title: Social Security Financing Amendments of 1977.
3. Bill status: As reported by the House Ways and Means Committee, October 12, 1977.
4. Purpose of bill: The primary purposes of this bill are (1) to strengthen the financing of the social security system; (2) to reduce the effect of wage and price fluctuation on the system's benefit structure; (3) to extend compulsory coverage to employees of the federal government, of State and local governments and of nonprofit organizations; (4) to allow higher earnings for social security recipients; (5) to eliminate certain gender based distinctions.
5. Cost estimate:

TITLE I

DIFFERENCE BETWEEN SOCIAL SECURITY REVENUES UNDER CURRENT LAW AND HOUSE WAYS AND MEANS DECISIONS, UNIFIED BUDGET BASIS, MEASURED AS ESTIMATED WAYS AND MEANS REVENUES MINUS CURRENT LAW REVENUES[1]

[In billions of dollars]

Item	1978	1979	1980	1981	1982
OASI	0	2.1	4.0	6.8	8.8
DI	2.3	3.5	4.0	4.6	5.3
OASDI	2.3	5.6	8.0	11.4	14.1
HI	−1.0	−1.1	−.9	.2	.8
OASDHI	1.3	4.5	7.1	11.6	14.9

[1] Estimates based on Congressional Budget Office macroeconomic assumptions.

The above table displays the differences between revenues under current law and under the Ways and Means proposal. Total Old Age Survivors Disability Health Insurance (OASDHI) tax rates are not changed from current through calendar year 1980 under the Ways and Means proposal, but are increased above current law beyond 1980. Under the Ways and Means proposal, however, a larger share of OASDHI receipts go into the DI funds than under current law, with the HI fund receiving a smaller share than under current law.

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The Ways and Means proposal replaces the mechanism that automatically adjusts the level of the taxable maximum with set levels of taxable maximum. (Similar to current law, each year's taxable maximum applies equally to employers and employees.) The proposed taxtable maximums are on average $7,000 higher than the estimated levels under current law. The affect of this is to increase taxable wages and social security revenues.

Budget authority under the bill would increase by approximately the same amount as receipts in fiscal year 1978. Thereafter, budget authority would increase by more than receipts because of the additional interest income generated by the larger trust fund balances.

TITLES II–VIII.—EFFECTS ON OUTLAYS OF PROPOSED MAJOR PROVISIONS: INCREASES IN OUTLAYS FOR FISCAL YEARS 1978–83

[In billions of dollars]

	1978	1979	1980	1981	1982	1983
Decoupling[1]	0	0	−0.3	−0.7	−1.3	−2.1
Raise exempt amount in retirement test	(2)	.2	.2	.2	.3	.3
Limit windfall increases for early retirees	0	−.2	−.4	−.7	−.9	−1.2
Expand benefits to divorced spouses	0	.2	.2	.2	.2	.2
Elimination of marriage as a bar to benefit entitlement	0	1.3	1.4	1.6	1.7	1.9
Elimination of monthly retirement test	−.2	−.2	−.2	−.2	−.2	−.3
Elimination of retroactive benefits	−.2	−.4	−.5	−.6	−.6	−.6
Total[3]	−.4	.9	.4	−.2	−1.8	−2.8

[1] Includes freezing of minimum benefit and increment in delayed retirement credit.
[2] Less than $50,000,000.
[3] Total includes minor costs and savings of other provisions.

Background for the main estimates is given below.

TITLE II—STABILIZATION OF REPLACEMENT RATES IN THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE PROGRAMS

This provision changes the procedure for calculating primary insurance amounts for persons becoming eligible for old-age, survivor or disability benefits, starting January 1, 1979. A 10-year transition period allows new retiree (but not disability or survivor cases) the choice of calculating benefits on the new basis or using the 1979 benefit formula.

The new system is "decoupled" in that primary insurance amounts (PIA's) for new beneficiaries will be determined by a different procedure tran will be used to index benefits of existing beneficiaries. For the latter group, benefits will in effect be subject to the same automatic adjustments for charges in the Consumer Price Index as under current law.

Under the new procedure the PIA for new beneficiary awards would be calculated as: 90 percent of the first $180 of average indexed monthly earnings (AIME), 32 percent of the next $905 of AME and 15 percent of AIME over $1,085. The "bend points" in the formula are to be adjusted (i.e., indexed) each year for changes in average wages. As indicated in the bill the adjustments would be based on changes in "the average of the total wages reported to the Secretary of the Treasury." The precise construction of the average of the total wages is not specified by the bill, but is to be defined in regulations of the Secretary of Health, Education, and Welfare.

Because of the dependence on "wage indexing" in the new procedure, it is difficult to estimate the effects on costs of the new decoupled formula without knowing how "the average of the total wages" would be measured. One interpretation would be that an actual wage index would be constructed in a manner analagous to that of the Consumer Price Index. Such an index would be adjusted for changes in the experience and skill of the work force and would be unaffected by changes in hours and weeks worked per worker. Another interpretation of the bill would be that total wages would be the sum of wages subject to withholding, as reported to the Internal Revenue Service, and divided by the number of individuals reported on the withholding statements. In this case the change in average wages could be quite unpredictable and would be affected by factors such as changes in hours and weeks worked per individual and by changes in the rate of job turnover (since the number of different employees each wage earner works for would affect the total number of workers as reported by employers on their W-2 forms).

In addition to the provision for decoupling, the new benefit computation procedure provides that the regular minimum benefit would be frozen at the level in effect at the end of 1978 and that retirement benefits would be increased by 3 percent (instead of 1 percent as in current law) for each year retirement is delayed beyond the age of 65 and up to the age of 72.

The actuaries of the Social Security Administration have made the above estimates of the effect of decoupling (including the changes in the minimum benefit and the delayed retirement increment). The accuaries' estimates assume that for purposes of implementing the decoupling proposal "average earnings" would increase at a rate consistent with that shown in the 1977 trustees' report. The new benefit formula yields a saving over current law because under the trustees' assumptions of futue inflation, the relation between benefits and past earnings would rise faster than under the provisions of the bill.

TITLE III—COVERAGE UNDER OASDI

The bill extends mandatory coverage to employees of the federal government and to those employees of state and local governments and of nonprofit organizations who are not now covered. The provision is to take effect in 1982. The way in which the civil service retirement system and social security would be integrated is not specified in the bill but is to be the subject of a study made by the Secretary of Health, Education, and Welfare. The study would be expected to provide a plan by 1980.

Until the details of a plan are given it is not possible to estimate the potential costs or savings to the system or to the federal budget of extending social security coverage.

Other provisions of Title III would have negligible effects on revenues and outlays over the next five years.

TITLE IV—ELIMINATION OF GENDER-BASED DISTINCTIONS UNDER OASDI

The provisions of Part A which equalize the treatment of men and women with respect to different aspects of benefit eligibility would have a minor effect on outlays, increasing them by less than $5 million a year.

Part B would add two provisions with cost implications. The bill eliminates marriage or remarriage as a factor terminating or reducing benefits. For example, under current law a widow or widower who remarries loses eligibility for survivor benefits. The bill would allow such cases to retain survivor benefits after remarriage as long as other conditions of eligibility for survivor benefits were met. In addition, the bill reduces from 20 years to 5 years the duration-of-marriage requirement for divorced spouses of retired or deceased workers with respect to eligibility for spouse or survivor benefits.

The estimates were developed in the following way. It is known that there are about 400,000 married aged women who had been widows before remarriage. Not all would benefit under the new law since the widow's own benefit as a worker or her spouse benefit on her new husband's record could exceed her survivor's benefit on the deceased husband's record. It is known that about 69 thousand remarried widows in 1977 were receiving spouse benefits on their deceased husbands' records which they can now do under current law. This group would under the new law roughly double their benefits at a cost of about $120 million in 1979. In addition, it was assumed that another 200 thousand aged remarried widows would become eligible for the difference between their spouse benefits (or worker benefits) and their survivor benefits at an estimated cost of $260 million in 1979. Based on historical data on the number of terminations of benefits each year for widowed mothers (and children) because of remarriage (or marriage) it was estimated that an additional 350 thousand persons would qualify for benefits under the bill who would have had benefits terminated under current law. Additional costs for this group are estimated at about $850 million in 1979. Estimates on the provision for divorced spouses and survivors are those of the SSA actuaries.

TITLE V—CHANGE IN THE EARNINGS TEST

The bill would raise to $4,000 in 1978 and to $4,500 in 1979 the amount of earnings a beneficiary aged 65 to 72 years may have without losing any retirement benefits. Under current law these amounts are projected to be $3,240 in 1978 and $3,480 in 1979. After 1979, the exempt amount would rise based on the rise in annual earnings.

The estimate was based on files showing the earnings and potential benefits of persons aged 65 and over in 1973 and 1975. It was assumed that the relation between earnings and benefits would remain the same over time although the level of earnings and benefits would rise in accordance with CBO assumptions about wage increases and increases in the CPI. Because of the increase in the exempt amount some individuals who have lost all benefits would receive a benefit and many would receive higher benefits. The estimated increases in outlays are shown in the summary table above.

5. Estimate comparison: None.
6. Previous CBO estimate: None.
7. Estimate prepared by: June O'Neill.
8. Estimate approved by:

JAMES L. BLUM,
Assistant Director for Budget Analysis.

VIII. INDIVIDUAL VIEWS OF HON. SAM M. GIBBONS

The social security system is in a mess. This bill does not correct it . . . or even come close to correcting it. In some ways it makes the situation worse because, by increasing the taxes levied without correcting the fundamental problems of the system, the bill moves us away from a solution instead of toward one.

The social security program has both short run and long run problems. Both of these are serious. The bill attempts to solve the short run problems but it fails. It does not even attempt to solve the long run problems.

Once again we are raising revenues and once again we are increasing benefits. This cannot go on forever and in fact it has already gone too far.

At present there are slightly more than three persons in the nation's work force for each person drawing social security benefits. By the year 2015 A.D., there will be only one person in the work force for each person receiving benefits. At that time or before, there will be a revolt by those who are forced to carry the burden of financing this program.

The Ways and Means Committee has failed in its responsibility to produce a solution to the short run or the long run problems of the social security program. I cannot support this legislation.

Sam M. Gibbons.

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IX. DISSENTING VIEWS OF HON. JOSEPH L. FISHER

The Social Security financing bill as approved by the Ways and Means Committee is a big step toward reversing the outflow of funds from the Trust Funds of the system. Although I did not think the Committee should report the bill with the provision for universal coverage of all Federal, State, and local government and non-profit organization employees, I did believe that the balance of the bill offered many improvements. The bill accelerates the increase in the wage base subject to the employment tax; it corrects the overindexing of future benefits; it removes inequities in the treatment of widows, widowers, and divorced persons; it increases the amount of wages that retirees can earn before their Social Security benefits are reduced, and it provides standby loan authority to bolster the trust funds if they fall below a certain level. The net effect of these changes is to assure retirees and workers that the Social Security system will remain capable of paying them the benefits they have worked for and been promised by Congress. The increased taxes will continue to be shared equally by individuals and employers. Meeting the higher cost will not be pleasant, but it is necessary to put Social Security on a long-term basis. But the extension of mandatory coverage to government employees, even if set for 1982, is unwise at least until an analysis of the economic impact can be made, and in the case of Federal workers, a plan worked out and enacted to integrate Social Security with the existing Civil Service Retirement system without any loss or harm to government workers.

The tax increases and some other changes in the bill are intended and expected to keep the three Trust Funds from falling below 25 percent of annual payments. If the calculations are wrong and the reserves should be depleted below that level, then the bill would permit the Old Age and Survivors Insurance (OASI) and the Disability Insurance (DI) Trust Funds to borrow funds from the general treasury to replenish the reserves. No borrowing authority is provided for the Health Insurance Trust Fund which is in good condition anyway. To assure that the loans are repaid the committee also approved a temporary payroll tax increase to be triggered if the loans are made. Should that situation arise, I believe that the Subcommittee on Social Security should be expected immediately to develop a proposal to strengthen the system in order to eliminate the need to borrow, either by changing the tax rate, the wage base, benefits, or whatever is necessary. The standby loan authority may be a necessary psychological safeguard, but the Committee should never allow the system to become so weak that it has to be invoked.

The universal coverage provision is the most objectionable feature of the bill, not because coverage for all workers is inherently a bad policy, but because the consequences of extending mandatory coverage to the remaining 6 to 7 million workers not presently covered have not been fully explored. Nearly half these workers are Federal employees and most of the remainder work for state and local governments. The revenue to the system expected to come from universal coverage in 1982 is $13.5 billion. Because the tax is shared equally by employer and employee, half of this infusion of revenue will come from Federal, state, and local treasuries. The Committee may have rejected direct general revenue financing of Social Security but apparently it is willing to accept general revenues through the back door. The Federal employer share will have to be paid either from an increase in income taxes or in the deficit. The transfer of Federal general treasury funds to the Social Security Trust Fund will take place whether or not coordination is worked out between Civil Service Retirement and Social Security. Even more disturbing is the prospect that state and local governments will have to pay nearly $4 billion more in 1982 to the Federal treasury as the employer share of Social Security taxes. Some 30 percent of state and local government employees are not now under Social Security. These jurisdictions will have to raise the funds for the employer share in some way. One way would be to reduce existing pension benefits, which may not be permissible under the law. Another way would be to hike the property tax and other regressive taxes which are the mainstay of local government finance.

Since 1950 State and local governments have been able voluntarily to bring their employees under Social Security. The proportion of employees so covered reached the 70 percent level in the early 1960's and has been stable at that point. Clearly, for various reasons, state and local governments have decided that it was not in their best interests to bring the remainder of their employees under this coverage. Without a thorough study of those reasons, this Committee should not arbitrarily attempt to override such local decisions.

The issue of coverage of Federal workers has been examined several times, with the usual conclusion that a way should be found to fill in gaps in coverage rather than requiring full Social Security coverage. A report due from the Social Security Administration in consultation with the Civil Service Commission in 1972 was never submitted, apparently because a workable plan could not be agreed on for coordinating the Social Security system with the Civil Service Retirement system. Prior to that, a 1969 report from the Secretary of HEW found that ". . . the liberalization and independent development of the civil service retirement and social security systems over a long period of time present formidable obstacles to the adoption of the (universal) coverage approach."

In the absence of a plan for coordinating the two systems for Federal employees, and in the absence of accurate cost estimates, I must conclude that the Committee has acted in haste in mandating universal coverage. The Committee did accept my amendment to delay the effective date of coverage and to require the preparation of a plan to make sure that no Federal employee would be worse off under the combined systems than he would have been under the Federal system alone. But this puts the cart before the horse. The plan should be presented and considered by the appropriate committees of Congress before universal coverage is required.

If there are "formidable obstacles" to coordinating Social Security and Federal staff retirement systems, over both of which Congress has control, there probably would be even greater difficulties in doing the same for state and local systems. Some of these systems are poorly financed. It is possible that the state and local governments will abandon or sharply curtail these pension plans once they are faced with the added costs of Social Security. What would be the consequences of this kind of action for employees who had counted on these pensions for their old age? Would Social Security be adequate in such cases? The answer truly is that we do not know. We should not act to require the coverage until we do know.

From the point of view of costs and consequences to the employer in terms of new tax obligations, and to the employee in terms of changed or possibly diminished benefits, and to all taxpayers in terms of yet more taxes—we simply do not have adequate information from which we can conclude that the extension of universal coverage is prudent and fair at this time.

For these reasons I intend to offer an amendment when the Social Security financing bill is before the House of Representatives to remove the provisions for universal coverage.

X. MINORITY VIEWS OF HON. BARBER B. CONABLE, JR., HON. JOHN J. DUNCAN, HON. BILL ARCHER, HON. GUY VANDER JAGT, HON. WILLIAM A. STEIGER, HON. BILL FRENZEL, HON. JAMES G. MARTIN, HON. L. A. (SKIP) BAFALIS, HON. WILLIAM M. KETCHUM, HON. RICHARD T. SCHULZE, AND HON. WILLIS D. GRADISON, JR.

Most Americans are genuinely worried about the future of their social security system. They have reason to be.

The system is severely deficient, both in money and equity. The people who benefit from it, those who support it, and the following generations of participants, deserve a sound and far-reaching solution to social security problems. But they will not get it through the Committee bill.

The bill raises taxes too high and too soon, serving to depress an already shaky economy and to dampen job prospects at a time when the unemployment rate is hovering around an unhealthy 7 percent. The additional payroll levies which are imposed tilt the entire national tax structure even more lopsidedly against the already overburdened middle class in our society.

The bill falls far short of solving the system's long-range financial deficit, dumping this problem in the lap of the next generation. It leaves a 75-year social security deficit of 1.69 percent of taxable payroll, which translates into about $880 billion—a tidy sum our children will have to raise.

It fails to provide enough of the structural improvements which our changing society needs and wants, leaving the system with too many inequities and anomalies. Perhaps the most glaring example of the bill's inadequacies in this regard is its "tokenistic" handling of the earnings limitation on beneficiaries. Instead of removing the limit or increasing it substantially, the bill provides advances that are almost negligible.

The bill relies, for added revenue, on a rapidly accelerated taxable wage base—a ruse which: (1) victimizes middle-income Americans; (2) cuts sharply the money available for savings or for spending in the market place, and (3) deals a damaging blow to efforts toward greater capital formation, which is badly needed in our struggling economy today. Increases in the wage base provide revenue in the short-term, but do not help over the long run because the added funds must be paid out in higher benefits later.

It opens a door to general revenue financing by requiring the social security trust funds to borrow from the Treasury whenever year-end reserves drop below 25 percent of annual outgo. Although projections indicate this borrowing might not take place, the provision sets a potential precedent which is bad policy on two main counts:

(1) If the system is supported by money other than that contributed by participants, then its insurance character is under-

mined and benefits eventually are likely to be paid on the basis of one's need, not one's earned right.

(2) The Treasury already has a huge deficit, therefore a transfer from general funds to the social security trust funds means Treasury will have to borrow more money, which increases the public debt and ultimately produces higher taxes and greater inflation for all.

The Committee bill has some sensible provisions, but because of the major flaws cited above, our opinion of it can be summed up in one short sentence: There has to be a better way.

We have developed what we believe to be a better way, in a comprehensive, 15-point "Proposal for Financial Restoration and Equity Strengthening of the Social Security System". We intend to offer this Proposal, which is described below, as a substitute for the Committee bill when it reaches the Floor of the House. We encourage our colleagues to compare and contrast the two.

We acknowledge that some elements of our Proposal are politically controversial. But we have had to face the fact that, when it comes to dealing squarely with social security problems, there is no "free lunch".

There also are no easy choices, yet choices must be made, because the problems will not go away.

We hope our colleagues will join us in making a difficult choice—now. A vote against both alternatives available would be a vote in favor of imminent bankruptcy for the social security system. Here are some comparisons for consideration:

The Committee bill takes care of the system's financial problems on a short-range basis only, it fails to address such equity issues as that of the working wife, it tends to weaken the system's insurance character, and it unwisely and unnecessarily calls for substantial tax increases, starting next year.

Our Proposal, which is designed to be considered as an indivisible unit, would put the system on a sound financial footing for at least the next 75 years; correct numerous inequities, particularly those related to the treatment of women; and strengthen the insurance character of social security. It would do all this with no new tax increase until 1981 and with less than a 1¼ percent tax increase over that scheduled under present law for the entire 75-year span.

The Committee bill raises the amount of money a retiree aged 65 or older can earn without having benefits reduced by a total of only $1,020 more than present law over the next two years.

Our Proposal removes the earnings limitation entirely for those beneficiaries by 1980.

In terms of the actual burdens on those who pay social security taxes, these additional comparisons might be made:

The Committee bill requires much higher taxable wage bases than under present law (totaling $6,000 by 1981) for employees, employers and the self-employed.

Our Proposal does not raise the taxable wage base above what would result under present law.

In terms of actual dollar outlays over the next five years, contributors at the maximum rate would have to pay an estimated $1,475.25 more under the Committee bill than under our Proposal. That's a difference of nearly $300 per taxpayer per year.

In summary, the Committee bill costs more than our Proposal, both in the near future and over the long run, while it offers less in terms of structural improvements.

For that reason, we think our Proposal is a bargain. There are prices to pay for the problems it solves. But the prices are reasonable, in view of alternatives, including the Committee bill.

Our "Proposal for Financial Restoration and Equity Strengthening of the Social Security System" has five general objectives. It would: (1) Make the social security system financially sound for at least the next 75 years; (2) Strengthen the insurance character of the system; (3) Improve the treatment of women under the system; (4) Make long-needed adjustments to reflect changes in living and working patterns of the American people; (5) Move toward universal coverage—appropriate for a nationwide, mandatory social insurance system.

The most important objective is restoration of the financial soundness of the system, which faces an estimated deficit of 8.2 percent of taxable payroll over the next 75 years. This proposal would virtually eliminate that long-term deficit. It also would solve the serious cash-flow problems facing the Social Security trust funds now and in the near future.

ANALYSIS OF THE PROPOSAL FOR FINANCIAL RESTORATION AND EQUITY STRENGTHENING OF THE SOCIAL SECURITY SYSTEM

SHORT-TERM FINANCING

The financial problems facing the system between now and 1981 would be taken care of through: (1) reallocation of Social Security taxes between the Old-Age and Survivors Insurance (OASI) and Disability Insurance (DI) Trust Funds; and (2) a temporary reassignment of an increase in the tax rates for the Hospital Insurance (HI) Trust Fund, which already (under existing law) is scheduled to take place next year.

The current OASDI tax rate of 9.9 percent (on employers and employees combined) now is allocated: 1.15 percent for DI and 8.75 percent for OASI. It should be reallocated: 1.5 percent for DI and 8.4 percent for OASI. The increased allocation of 0.35 percent to the DI Trust Fund would be sufficient to prevent it from becoming exhausted by 1979 (as can be expected without a change in the law). Reallocation also would cause both Funds to remain viable at least until 1981.

In order to assure further the viability of these two Trust Funds, and to cover the cost of certain improvements in the system starting next year, part of the scheduled increase in the HI tax rate would be diverted temporarily to the OASDI Trust Funds. Present law calls for an increase in the HI tax rate, starting in 1978, from 0.9 percent to 1.1 percent for each employee, employer, and self-employed person. Three-fourths of this increase, or 0.15 percent per worker and employer, would be directed to the OASDI Trust Funds beginning January 1, 1978 and ending December 31, 1981. (This not only would bolster those two Funds, but also would permit a three year phase-out of the earnings limitation starting January 1, 1978.)

[In addition, one-fourth of the 1978 increase in the HI tax rate (i.e., 0.05 percent for both workers and employers) would be permanently directed to the OASDI Trust Funds after 1981. This would not adversely affect the operation of the HI Trust Fund, because the amount of money involved in the diversion is less than the savings to this fund as a result of providing for universal coverage.]

To guarantee the financial viability of all three Trust Funds over the next several years, each should be permitted to borrow from another, solely for the purpose of preventing exhaustion and with appropriate arrangements made in each case for repayment with interest.

(Following are tables showing the 10-year and the 75-year impact of this Proposal on the OASDI Trust Funds:)

PROGRESS OF OASDI TRUST FUNDS UNDER THE PROPOSAL FOR FINANCIAL RESTORATION AND EQUITY STRENGTHENING OF THE SOCIAL SECURITY SYSTEM

[In billions of dollars]

	Income	Outgo	Net income	Fund at end of year
Year:				
1977	82.1	87.6	−5.5	35.6
1978	93.1	98.2	−5.1	30.4
1979	103.1	110.0	−6.9	22.5
1980	113.0	123.3	−10.3	13.2
1981	134.1	134.4	−.3	12.9
1982	153.9	145.2	+8.7	21.6
1983	166.8	157.1	+9.7	31.3
1984	178.5	169.7	+8.8	40.1
1985	204.8	182.9	+21.9	62.0
1986	220.3	196.9	+23.4	85.4
1987	236.6	211.6	+25.0	110.4

Long-range (75-yr) impact of proposal for financial restoration and equity strengthening of the social security system

[Impact on long-term OASDI trust funds' deficit loss or gain as percentage of taxable payroll]

Provision:	
Decoupling and wage-indexing based on preautomatic adjustment flaw	+4.71
Freezing regular minimum benefit and updating special minimum benefit	+.09
Increasing the retirement age after 2000	+1.35
Eliminating windfall for early retirees	+.24
Limiting disability and survivor benefits to maximum retiree benefits	+.02
Extending coverage	+.34
Cutting marriage duration requirements for divorcees' eligibility from 20 to 5 yr	−.01
Removing benefit cutoff or reduction for marriage or remarriage	−.08
Adding working spouse's benefit, with offset for other governmental pension	−.65
Ending the earnings limitation for those aged 65 or older	−.25
3-stage tax rate increase and HI tax diversion	+2.21
Total net effect	+7.97
Deficit under present law	8.20
Deficit under proposal	.23

NOTE.—The system is considered to be within safe actuarial bounds (sufficiently close to absolute balance) if the deficit is no greater than 0.67 percent of taxable payroll.

LONG-RANGE FINANCING

(1) The long-term deficit of the system would be reduced by slightly more than 50 percent through a process called "decoupling", plus wage indexing of the earnings record of the insured worker.

Decoupling was made necessary by what has been termed an inadvertent flaw in the 1972 law which adjusts benefits automatically according to annual increases in the Consumer Price Index. Under the present coupled system, the CPI increases are applied both to payments already being paid to those on the benefit rolls and to the benefit formula which is applicable to future beneficiaries. Decoupling would apply the cost-of-living percentage increases only to current beneficiaries.

The proposal parallels the decoupling-plus-wage-indexing provisions of the Committee bill. For future retirees it equitably stabilizes wage replacement ratios (the relationships between benefits and the earnings on which those benefits are based). To some extent, it would adjust the ultimate benefit level for the overexpansion that has occurred since the automatic-benefit-increase provision was enacted.

This does not mean that benefits would be reduced for those currently receiving benefits. They would be treated exactly as under existing law. Whenever the cost-of-living (as measured by the Consumer Price Index) advances in a year by 3 percent or more, benefits would continue to be increased commensurately.

Nor does it mean that dollar amounts of benefits paid in the future would be lower than present levels. To the contrary, dollar amounts—as well as the purchasing power of benefits—for future retirees would be higher than present levels.

It is important to note that, under this proposal, a 10-year savings clause—or guarantee—would be provided so that no retiree would receive less during that time than he or she would under the present-law formula as it was at the time of the change. In other words, retirees would have their choice. They could take the benefit available under present law at the point of changeover, or they could take the benefit provided under the new method, whichever is larger.

(2) The long-range deficit would be reduced further through a slow, gradual and distant advancement in the retirement age at which full benefits are payable. This proposal would move that age from 65 to 68, by degrees, not starting until the turn of the century and ending in 2011.

We recognize that this is an extremely sensitive issue, one that is conceptually difficult for very young workers to accept, and one that is politically difficult for our colleagues to embrace. But we believe it is an issue which the Congress will be forced to face evenutally, for reasons outlined below, and we hope our colleagues will have the courage to confront it now.

The fairest thing to do would be to give the young workers and potential workers, who would be affected by such a change, as much advance notice as possible. The most unfair thing would be to wait until the change proved to be inevitable and to act without warning.

In considering this proposed change, which would affect only those workers aged 39 or younger and would have maximum impact only on those young than 30, our colleagues are urged to take the following factors into account:

When the Social Security system was enacted, 42 years ago, American workers were not living as long as they are now, nor were they as productive for as long a period of time. In the next century, longevity for men will have increased by about three years, and for women, by about seven years. From time to time, the system has responded to other changes in the working and living habits of the people it serves, and it is reasonable for the system to adjust to these trends also.

It should be borne in mind that while longevity is expected to continue increasing in the foreseeable future, the birth rate has declined drastically and may well continue downward (or else remain at a low level) for years to come. This means there will be fewer workers making contributions, but more retirees receiving benefits. For example, there are now more than three workers contributing to the Social Security system for every beneficiary. But in the next century, that ratio will drop dramatically. There will be only two contributing workers for every one beneficiary.

In view of (1) these demographic projections, (2) the improvement in mortality as well as the physical conditions of older people, and (3) widespread dissatisfaction with mandatory retirement practices—which the Congress has recognized in recently passed legislation—this proposed change can have a salutary impact both on the Social Security system and on the social and economic lives of the American people.

Workers could continue to retire as early as 62, but with slightly greater actuarial reductions than at present, to take into account the longer period of time over which they could be expected to receive benefits.

Specifically, the standard retirement age of 65 would be increased by three months (or one-quarter year) each year starting in 2000. By the year 2011, the minimum retirement age for full benefits would have been increased to 68.

A gradual implementation of this change, with an effective date 33 years in the future, would give people sufficient time to plan for their retirement without severe disruption in any one year, and would permit management and labor to revise employment practices carefully and systematically.

The cost equivalent of not making this change would be an average tax rate increase on each social security contributor of 0.68 percent, starting next year and continuing through 2053.

(3) As noted earlier, the long-range deficit in the OASDI Trust Funds would be reduced additionally by a permanent reassignment, starting in 1982, of a small portion of the Hospital Insurance tax rate. This redirected rate would equal 0.05 percent for workers, employers, and the self-employed.

(4) To further strengthen the financing of the system in future years, contribution rates for employees, employers, and the self-employed would be increased by 0.50 percent in 1981, 0.45 percent in 1985, and 0.25 percent in 2000. Thus, the net addition to the presently-scheduled OASDI tax rates over the next 75 years would be 1.2 percent on employees, employers, and the self-employed.

The proposal would make significant changes in the Social Security Act designed to improve the treatment of women and to remove remaining sex discrimination language.

First, the proposal would reduce from 20 years to 5 years the duration-of-marriage requirement for one spouse to receive a benefit based on the other's earnings record. Under present law, a divorced spouse retains auxiliary benefit rights only if the divorce occurs after 20 full years of marriage. Critics of the system long have contended that this requirement was unfair, arbitrary, and unrealistic in view of societal changes.

Second, the proposal would end the cutoff or reduction in benefits for those who remarry. Under present law, for example, a widow's remarriage will reduce or cut off entitlement to benefits unless the subsequent marriage ends. A number of persons, especially those living in retirement communities, have complained that current law requires them to "live in sin" in order not to lose Social Security benefits.)

Third, the proposal would amend the Social Security Act to remove remaining sexually discriminatory language.

(All three of the above changes have been incorporated in the Committee bill.)

Fourth, the proposal would provide a new "working spouse's benefit". Under present law a covered worker is always eligible for a benefit based on his or her own earnings record. But if the worker also becomes entitled to an auxiliary benefit, such as a spouse's benefit, he or she is entitled only to the higher of the two benefit amounts available. A number of working spouses (especially wives) have found that they would have been as well off financially, as far as Social Security benefits were concerned, if they had never left the home to enter the labor force. To alleviate this problem and to provide greater recognition of the employment record of a working spouse, the proposal would make the following changes:

1. A spouse who is eligible for an auxiliary or survivor benefit, who also worked under Social Security, could receive a new "working spouse's benefit", which would be equal to (A) the larger amount due either as a spouse or as a worker, plus (B) 25 percent of the smaller of the two benefits (but in no event greater than the maximum primary benefit). Only one spouse would be eligible for this new benefit.

2. Any pension or benefit based on governmental employment not covered under Social Security would be considered as a primary benefit in determining the amount of the Social Security auxiliary or survivor benefit payable. (This change is designed to remove what amounts to a "windfall" benefit in some cases under present law. For example, if a wife worked under Social Security for her entire career, she would be entitled to a primary benefit based on her own earnings record. If her husband had worked exclusively under a state employee's retirement system, he would be entitled to a pension under that system and also might be entitled to an auxiliary (spouse's) benefit based on his wife's Social Security record. Inasmuch as auxiliary and survivors benefits are based more on social adequacy (or need) than on individual equity, the "windfall" situation described above is not one which the Congress contemplated when it provided for survivors and auxiliary benefits in the first place.)

UNIVERSAL COVERAGE

Universal coverage is a natural and desirable goal of any nationwide, mandatory social insurance system. Although about nine of every 10 American workers now participate in the U.S. social security system, it is increasingly difficult to justify to the "nine" why the "one" is not covered. This is especially true in view of the impact of the Social Security payroll tax on the incomes of contributors.

Public discussion of universal coverage has taken place for many years. It has long appeared that a large majority of Americans favor it, but no action has been taken by the Congress. Many difficulties—legal and administrative—have stood in the way.

But the latest Advisory Council on Social Security stated that despite these difficulties, "it is of great importance from the standpoint of assuring good protection for all workers on an equitable basis that all jobs be compulsorily covered under social security". The Council urged the Congress to move promptly toward that goal.

We initially proposed extending coverage to Federal workers only, under a plan that would fully protect their current pension rights and assure them of equitable treatment under an integrated plan in the future. Since then, the Committee has called for extending coverage also (by January 1, 1982) to employees of states, localities and nonprofit organizations. Although we have some reservations about legal and administrative problems associated with covering these additional groups, we accept the Committee's decision in this matter and herewith modify our Proposal accordingly.

INSURANCE AND EQUITY STRENGTHENING

To strengthen the insurance character of the system and, at the same time, to provide greater equity, the proposal also would:

1. Remove the earnings limitation on those who have reached the eligibility age for full retirement benefits. More bills have been introduced to abolish the limitation than to make any other change in the system. During recent public hearings before the Ways and Means Committee's Subcommittee on Social Security, repeal of the limitation was the most widely discussed item. Witnesses pointed out that it enforces the under-utilization of experienced older people and also encourages retirees to adopt artificial work and pay practices. Under this proposal, the limitation as it applies to full-term retirees, would be phased out over a 3-year period, by increasing the annual exempt amount of earnings to $5,000 for 1978 and to $7,500 for 1979, and by removing it entirely for 1980 and thereafter.

2. Freeze the minimum primary benefit at its expected June, 1978 level of about $120 per month, but at the same time increase, now and in the future, the special minimum benefit.

Freezing the minimum primary benefit follows a recommendation of the latest Advisory Council on Social Security, and is designed to lessen, and eventually eliminate, certain "windfalls" accruing to persons who work in covered employment for very short periods of time and thus acquire rights to the relatively large minimum, which has been weighted in favor of low-income workers.

In practice, a substantial number of Federal, state, and municipal government workers, outside the Social Security system, have either "moonlighted" or retired early from their regular jobs and worked under Social Security just long enough to obtain the minimum primary benefit.

Ironically, the minimum primary benefit was not established to help those short-term workers, but to assist other workers who had labored long under the system, at low wages. Recognizing that the minimum primary benefit was not serving its basic purpose, the Congress in 1972 added a "special minimum benefit" to better take care of the workers with many years of covered service at relatively low wages.

In so doing, the Congress did not change the minimum primary benefit, which continues to be of greatest value to those who need it least. This proposal would correct that anomaly by freezing the minimum primary benefit while improving the special minimum benefit.

The special minimum is now $180 per month for workers with at least 30 years of coverage. When the $180 figure was adopted in the 1973 Social Security Amendments (effective for March 1974), it was not made subject to the automatic adjustments for changes in prices; if it had been, it would now be $219.

Under this proposal, the special minimum would be increased to $219 in January 1978 and would be subject to automatic adjustment thereafter (as are all other benefits).

(These changes also parallel provisions of the Committee bill.)

3. Provide that disability and survivorship benefits would be based on a primary benefit not in excess of the maximum primary benefit for a worker reaching minimal retirement age of 62 in the year of death or disability.

Under current law, benefits to younger beneficiaries often are considerably larger than those awarded to older disabled persons or retirees with much longer earning records (and therefore with greater contribution payments). This disparity in benefit levels, which has long been considered inequitable, would end with this proposal.

Barber B. Conable, Jr.
John J. Duncan.
Bill Archer.
Guy Vander Jagt.
William A. Steiger.
Bill Frenzel.
James G. Martin.
L. A. Bafalis.
William M. Ketchum.
Richard T. Schulze.
Bill Gradison, Jr.

XI. ADDITIONAL MINORITY VIEWS OF HON. WILLIAM M. KETCHUM

The restoration of our social security system to financial stability is of major consequence not only to individual participants in the program but also to the citizenry as a whole. It represents society's backup system to ease the hardships caused by an abrupt cessation of earned income. While the Ways and Means Committee's recommendations, as contained in H.R. 9346, parallel my views in several areas, the bill fails to put the social security system on a sound financial footing for the next 75 years.

The Committee bill would increase sharply the wage base on which employers and employees pay taxes. For instance, an individual earning $25,000/year would contribute $1,203.95 in 1978, $1,612.50 in 1981, and $1,687.50 in 1985, and an individual earning $10,000/year would contribute $605 in 1978, $645 in 1981, and $675 in 1985. I strongly cautioned against these proposed sudden and large increases in the wage base beyond what is presently scheduled. While almost everyone agrees that there should be some rise in the wage base, current law already provides for an annual inflation adjustment which is projected to increase the wage base sufficiently from $16,500 to $17,700 in 1978, and by increments of $1,500 each year after that. In the long run, increasing the wage base with respect to employees and the self-employed does *not* provide any significant revenues for the system because the additional taxes collected are very closely offset by the additional benefits created.

In addition, the Committee bill would impose an unnecessary, harsh increase in the tax rate over and above the scheduled rise, too soon in the wake of high rates of inflation and unemployment. Furthermore, H.R. 9346 will leave us with a minimum deficit of *$800 billion over the next 75 years.*

The Committee did have alternatives which it could have taken and chose not to. A number of my colleagues and I advised that the bulk of new funding for the social security system should come from the existing payroll tax method. Most of the burdensome taxes could have been eliminated by a consolidation of the Old-Age and Survivors Insurance (OASI) and Disability Insurance (DI) and the Hospital Insurance (HI) trust funds to insure the financial viability of all three trust funds over the next few years. The adoption of our alternative plan would virtually eliminate the short-run deficit, thus obviating the need for such steep wage base and tax rate increases. Small tax rate and wage base increases would then be sufficient to eliminate a good portion of the deficit.

Although the Committee bill does address a number of long-standing inequities, the long and short term financing components of the bill will severely impact the working populace and further depress the economy without insuring a financially sound social security trust fund. Those of us who believe that our social security system should be restored to financial stability on a long-range basis without 1) adding heavily to tax burdens in the future; or 2) requiring any tax increases over the next several years, in light of an uncertain economy and current payroll levies on both employers and employees, will make every effort to have our alternative proposals adopted in lieu of the committee bill when social security reform legislation comes before the House floor.

BILL KETCHUM.

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95th Congress, 1st Session - - - - - House Report No. 95–702, Part 2

COVERAGE OF FEDERAL EMPLOYEES WITHIN THE SOCIAL SECURITY SYSTEM

REPORT

OF THE

COMMITTEE ON POST OFFICE AND CIVIL SERVICE

ON

H.R. 9346

TO AMEND THE SOCIAL SECURITY ACT AND THE INTERNAL REVENUE CODE OF 1954 TO STRENGTHEN THE FINANCING OF THE SOCIAL SECURITY SYSTEM, TO REDUCE THE EFFECT OF WAGE AND PRICE FLUCTUATION ON THE SYSTEM'S BENEFIT STRUCTURE, TO PROVIDE COVERAGE UNDER THE SYSTEM FOR OFFICERS AND EMPLOYEES OF THE UNITED STATES, OF THE STATE AND LOCAL GOVERNMENTS, AND OF NONPROFIT ORGANIZATIONS, TO INCREASE THE EARNINGS LIMITATION, TO ELIMINATE CERTAIN GENDER-BASED DISTINCTIONS AND PROVIDE FOR A STUDY OF PROPOSALS TO ELIMINATE DEPENDENCY AND SEX DISCRIMINATION FROM THE SOCIAL SECURITY PROGRAM, AND FOR OTHER PURPOSES

OCTOBER 17, 1977.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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95TH CONGRESS } HOUSE OF REPRESENTATIVES { REPT. 95-
1st Session } { 702 Part 2

COVERAGE OF FEDERAL EMPLOYEES WITHIN THE SOCIAL SECURITY SYSTEM

OCTOBER 17, 1977.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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Mr. NIX, from the Committee on Post Office and Civil Service, submitted the following

REPORT

[To accompany H.R. 9346]

The Committee on Post Office and Civil Service, to whom was referred the bill (H.R. 9346) to amend the Social Security Act and the Internal Revenue Code of 1954 to strengthen the financing of the social security system, to reduce the effect of wage and price fluctuation on the system's benefit structure, to provide coverage under the system for officers and employees of the United States, of the State and local governments, and of nonprofit organizations, to increase the earnings limitation, to eliminate certain gender-based distinctions and provide for a study of proposals to eliminate dependency and sex discrimination from the social security program, and for other purposes, having considered the same, report favorably thereon with amendments and recommend that the bill as amended do pass.

The amendments are as follows:

Page 164, strike out line 20 and all that follows down through line 3 on page 168 and insert in lieu thereof the following:

STUDY CONCERNING MANDATORY COVERAGE OF FEDERAL EMPLOYEES

SEC. 301. (a) As soon as possible after the date of the enactment of this Act, the Chairman of the Civil Service Commission, the Secretaries of the Treasury and Health, Education, and Welfare, and the Director of the Office of Management and Budget, shall jointly undertake and carry out a detailed study with respect to coverage of Federal employees within the old-age, survivors, and disability insurance system.

(b) The study to be undertaken under subsection (a) shall include—

(1) a review of the methods by which full coverage of Federal employees within the old-age, survivors, and disability insurance system could be attained;

(2) an analysis of the adjustments to such system (as well as to the civil service retirement and disability system and other Federal employee retirement systems involved, including the foreign service, judiciary, Central Intelligence Agency, and District of Columbia retirement systems) which are necessary under each such method to provide such coverage, particularly—

(A) adjustments in age, service, and other eligibility requirements; and

(B) adjustments in the nature and level of disability, death, and survivor benefits (taking into account any related factors, such as the taxability of such benefits);

(3) a comparison of the financial aspects of each such method, particularly—

(A) the adjustments required by each such method in the contributions by Federal employees, the Government (whether by specific contribution or by appropriation), and others involved;

(B) the adjustments required by each such method in the manner in which benefits are financed under the retirement systems involved; and

(C) the effects of each such method on the solvency of the retirement systems involved;

(4) the effects of each such method of coverage on—

(A) recruitment and retention of Federal employees;

(B) other employee benefits (such as health benefits coverage provided for civil service annuitants); and

(C) Federal. State. and local income tax systems;

(5) a review of the methods by which partial coverage of Federal employees within the old-age, survivors, and disability insurance system could be attained, together with consideration of the factors described in paragraphs (2), (3), and (4) as they would relate to such partial coverage; and

(6) alternatives to providing coverage of Federal employees within the old-age, survivors, and disability insurance system which would improve the solvency of the old-age, survivors, and disability insurance system.

In connection with such study. interested parties, including Federal employee organizations, associations of retired Federal employees. and heads of agencies administering Federal employee retirement systems, shall be allowed to submit views, arguments, and data.

(c) Upon the completion of the study under subsection (a) and in any event no later than 2 years after the date of the enactment of this Act, the Chairman of the Civil Service Commission, the Secretaries of the Treasury and Health, Education, and Welfare, and the Director of the Office of Management and Budget shall submit to the President and to the appropriate committees of each House of the Congress a joint report on the results of such study together with their recommendations. Any such recommendation which includes adjustments of existing statutes shall be accompanied with draft legislation accomplishing such adjustments.

(d) With respect to Federal employees under the Federal employee retirement systems, the study and the report under this section shall include at least one method of coverage of such employees within the old-age, survivors, and disability insurance system which provides—

(1) that the benefits available to such Federal employees would not be less favorable than the benefits which are then currently available to such employees under the Federal employee retirement systems; and

(2) that the contributions required of such Federal employees would not be greater than the contributions which are then currently required of such employees under the Federal employee retirement systems.

(e) For purposes of this section, the term "Federal employee" means—

(1) an employee, as defined in section 2105 of title 5, United States Code;

(2) an officer or employee of the United States Postal Service or of the Postal Rate Commission; and

(3) any other individual in the employ of the United States or any instrumentality of the United States.

Page 175, line 4, strike out "Federal, State," and insert "State".

Page 175, line 11, strike out "Federal, State" and insert "State".

Page 175 strike out line 15 and all that follows down through line 23.

Page 175, line 24, strike out "(2) (A)" and insert "(1) (A)".

Page 176, line 9, strike out "(3) (A)" and insert "(2) (A)".

Page 176, beginning on line 21, strike out "paragraph (1), (2), or (3)" and insert in lieu thereof "paragraph (1) or (2)".

Page 188, beginning on line 21, strike out "redesignating paragraphs (8) through (20) as paragraphs (5) through (17)" and insert "redesignating paragraphs (7) through (20) as paragraphs (5) through (18)".

Page 189, line 2, strike out "210(a) (6)" and insert "210(a) (7)".

Page 189, line 5, strike out "paragraph (6)" and insert "paragraph (7)".

Page 189, line 9, strike out "210(a) (11) (B)" and insert "210(a) (12) (B)".

Page 189, line 12, strike out "210(a) (13)" and insert "210(a) (14)".

Page 189, line 15, strike out "210(a) (8), (9) or (12)" and insert "210(a) (9), (10), or (13)."

Page 189, line 18, strike out "210(a) (17)" and insert "210(a) (18)".

Page 189, beginning on line 22, strike out "redesignating paragraphs (8) through (20) as paragraphs (5) through (17)" and insert "redesignating paragraphs (7) through (20) as paragraphs (5) through (18)".

Page 190, line 5, strike out "3121(b)(11)(B)" and insert "3121(b)(12)(B)".

Page 190, line 8, strike out "3121(b)(13)" and insert "3121(b)(14)".

Page 190, line 11, strike out "3121(b)(8), (9) or (12)" and insert "3121(b)(9), (10), or (13)".

Page 190, line 14, strike out "3121(b)(17)" and insert "3121(b)(18)".

Page 190, line 18, strike out "(b)(6)" and insert "(b)(7)".

Page 190, beginning in line 22, strike out "(b)(5)' and 'section 210(a)(5)" and insert "(b)(6)' and 'section 210(a)(6)".

Page 191, beginning in line 2, strike out "3121(b)(6)" and insert "3121(b)(7)".

Page 191, line 7, strike out "210(a)(6)" and insert "210(a)(7)".

SUMMARY OF COMMITTEE AMENDMENTS

The committee amendment strikes out those provisions of H.R. 9346, as reported by the Committee on Ways and Means, which require mandatory social security coverage for Federal employees, and those provisions which relate to a study by the Secretary of Health, Education, and Welfare.

Instead, the committee amendment provides for a joint study by the Chairman of the Civil Service Commission and the Secretary of Health, Education, and Welfare (the agencies which administer the two systems primarily affected) and, in addition, the Secretary of Treasury and Director of OMB. The study is required to be completed not later than 2 years after the date of enactment of H.R. 9346, and the Chairman, the Director, and the Secretaries, are required to consider the views of interested parties, including Federal organizations, associations of retired Federal employees, and heads of agencies administering Federal retirement systems, for example, CIA, Secretary of State.

The amendment details specific issues which must be considered, including alternative financing methods (particularly, necessary adjustments in contribution rates by the Government, employees, and others, and the costs of various alternatives); alternative methods of providing coverage; the effect on solvency of the various systems affected; and the effects on Federal, State, and local income tax systems.

The amendment requires that the report must include at least one alternative which provides that Federal employees' benefits will not be reduced and contributions will not be increased.

Finally, the amendment makes necessary conforming changes in other sections of the bill.

A detailed explanation of the committee amendment is set forth below under the heading "Analysis of Committee Amendment".

COMMITTEE ACTION

On October 13, 1977, the Committee on Post Office and Civil Service ordered H.R. 9346 reported to the House, with an amendment, by a unanimous voice vote.

The committee amendment was adopted by a record vote of 25–0.

SEQUENTIAL REFERRAL

H.R. 9346, the "Social Security Financing Amendments of 1977", was introduced on September 27, 1977, and was referred solely to the Committee on Ways and Means. An earlier version of the Social Security Financing Amendments, H.R. 8218, had been considered by the Subcommittee on Social Security of the Committee on Ways and Means. H.R. 8218, as introduced, did not contain provisions relating to social security coverage for Federal employees.

During its markup of H.R. 8218, the Subcommittee on Social Security adopted a provision to require mandatory social security coverage for Federal employees beginning in 1980. This provision was included as section 301 of a clean bill, H.R. 9346, which the subcommittee on September 23, 1977, approved for consideration by the full Committee on Ways and Means.

Under clause 1(o) of House Rule X, the Committee on Post Office and Civil Service has jurisdiction over all matters relating to the "status of officers and employees of the United States including their compensation, classification, and retirement". Accordingly, by letter dated September 29, 1977, Chairman Robert N. C. Nix advised Chairman Al Ullman of the Committee on Ways and Means of this committee's concern with respect to the provisions of H.R. 9346 relating to Federal employees and detailed several specific objections of the committee. Subsequently, during markup by the full Ways and Means Committee, an amendment was adopted changing the effective date of mandatory coverage for Federal employees from 1980 to 1982, and requiring that a study be conducted by the Secretary of HEW to determine the method by which such coverage would be attained.

On October 4, 1977, Chairman Nix formally advised the Speaker of the committee's concern with section 301 of H.R. 9346, expressed his views with respect to this committee's jurisdiction over such matters, and requested that H.R. 9346 be sequentially referred to this committee. On October 5, 1977, following a meeting of the caucus of the Democratic members of the Committee on Post Office and Civil Service, Chairman Nix again wrote to the Speaker regarding the committee's concern with section 301 and requested sequential referral. The October 5 letter was cosigned by 22 of the remaining 24 members of the committee.

On October 12, the Committee on Ways and Means reported H.R. 9346, and the bill was sequentially referred by the Speaker to the Committee on Post Office and Civil Service for a period ending no later than October 17, 1977. As noted above, under the heading "Committee Action", this committee ordered H.R. 9346 reported to the House, with an amendment, on October 13, 1977.

STATEMENT

The committee unanimously recommends against approval, at this time, of mandatory coverage under the Social Security Act for Federal employees.

At the outset we wish to emphasize that our opposition is not based on the judgment that such social security coverage is not proper, desirable and equitable, but on the grounds that the precipitous action taken by the committee on ways and means, which seeks to cure, may, in fact, complicate the myriad problems presently troubling the Social Security System. Further, such mandatory coverage may have an adverse and detrimental effect on the various financially sound retirement systems for Federal civilian employees.

We seriously doubt that any one is of the opinion that Federal employees should be included under the Social Security System regardless of whether a plan, fair and equitable to all parties, can be developed and subsequently implemented.

Simply stated, extending mandatory coverage, at this time, without assurance that it is workable, is putting the cart before the horse.

Issues to be considered

The issues to be addressed and considered before a rational judgment can be made on the question of extending social security coverage to Federal employees include the following:

The financial problems of the Social Security Fund may not be resolved by integrating the civil service retirement system with social security. The fiscal ramifications of integrating the Civil Service Retirement System with social security are complex and must be studied thoroughly before such a move is taken. Integration could result in greater costs to the Government, unless present benefits available to Federal employees under both systems are reduced. Apparently, this latter condition has been rejected by the Committee on Ways and Means when it states in its report on H.R. 9346:

> The bill directs the Secretary of Health, Education, and Welfare to conduct a study with the Civil Service Commission to make recommendations for coordinating benefits and costs of the OASDI and Civil Service Retirement programs in such a way that Federal workers will be no worse off so far as costs and benefits are concerned compared to their treatment under present law.

There are 12 principle retirement systems for Federal employees of which the civil service system is by far the largest. The Foreign Service, the Central Intelligence Agency, and other agencies have separate retirement systems. Each of these systems should be carefully examined to determine how they should be restructured if social security is extended to the employees now subject to each system.

To cover Federal employees under social security without adjusting their coverage under civil service retirement or another retirement system for Federal employees would result in both employees and the Government having to contribute a substantial amount to both systems. Dual payments into both systems by both employees and Government would discourage employees, particularly at the lower grades, and limit the Government's ability to attract employees in the labor market.

How is integration to be accomplished? There are at least five basic alternatives:

(1) Offset existing civil service retirement annuity when annuitant becomes eligible for social security benefits, like many private pension plans do.

(2) Restructure civil service retirement as an add-on to the social security benefits.

(3) Create a two tier, dual payment system, as was done with the railroad retirement system.

(4) Leave present system intact for present employees and extend mandatory social security coverage only to new employees.

(5) Eliminate civil service retirement for new employees, and contribute to their participation in Individual Retirement Accounts instead.

How will civil service retirement benefits be financed after integration? Once social security contributions reach 7.45 percent as proposed for 1990, will it be practically possible to require that an additional percentage be withheld from an employee's pay to finance civil service retirement benefits? Or, will it become necessary for the Government to assume the full cost of financing the continuation of the civil service retirement system?

Technical problems in extending social security to cover Federal employees abound. For instance:

Persons who are eligible for social security are also usually eligible for medicare. Would Federal employees become eligible for medicare? If so, the Federal Employees' Health Benefits program would have to offer a medicare supplement plan for all retirees, and for employees at age 65.

Federal employees are eligible for workers compensation benefits from the Office of Workers Compensation, Department of Labor. If Federal employees are brought under social security, which has differing disability benefits than civil service retirement, would Federal employee eligibility for compensation benefits have to be modified?

Civil service retirement benefits are subject to Federal income tax, while social security benefits are not. Any integration of benefits under the two systems is likely to have significant tax consequences for both employees and the Government. What impact would this have on the real value of benefits paid to former employees?

Social security contributions may not be refunded, but civil service retirement contributions may be refunded. Will employees continue to be able to withdraw retirement refunds and still qualify for social security?

What about those persons who have already acquired a "fully" insured social security benefit prior to becoming Federal employees subject to the civil service retirement system? Will they lose the benefit which they have already earned?

In the event that Federal employees are still eligible to retire under current provisions of the civil service retirement law after having been covered under social security, would the annuity be treated as earnings for the purposes of the earnings limitation under social security? If so, this could effectively bar any receipt of social security until age 72, at least.

Numerous administrative problems would also have to be resolved before civil service retirement or other Federal retirement systems could be integrated with social security. The record keeping systems differ. Should civil service retirement continue to be separately administered?

No final action should be taken by the House on the question of mandatory social security coverage for Federal employees until the Congress has answers to the issues and questions hereinbefore presented.

Further questions of intent raised

In the brief period (5 days) that the committee has had to consider H.R. 9346, as reported, it has become clear that the precipitous action by the Committee on Ways and Means in adopting section 301 actually goes far beyond the intent evidenced by that section's heading—"Coverage of Federal Employees".

Section 301(a)(1) of the reported bill strikes out paragraphs (5) and (6) of section 210(a) of the Social Security Act. Currently, these paragraphs exclude from social security coverage Federal employees. Specifically, paragraph (6)(A) excludes "service performed in the employ of the United States, if such service is covered by a retirement system established by a law of the United States." These paragraphs, however, also exclude numerous other types of "service performed in the employ of the United States," types of service which it may or may not be appropriate to bring under social security coverage.

For example, if section 301 is enacted, work performed in a Federal penal institution by an inmate will be creditable for social security purposes. It also appears that inmates would be eligible to receive credit for past service performed while serving time in a Federal prison as provided in section 304 of the bill as provided. Presumably then, an individual serving a life term will begin drawing social security benefits at age 62, or perhaps age 65, and receive retroactive quarter-of-coverage credit for prior time served.

Section 301 of the bill, as reported by Ways and Means, would also bring under social security the President, the Vice President, and Members of Congress, all of whom are now excluded under paragraph (6)(C)(i) of section 210(a) of the Social Security Act. More importantly, section 301 apparently would bring Federal judges under social security, and it is arguable that such an action would constitute an unconstitutional reduction in pay for sitting judges within the meaning of section 1 of Article III of the Constitution which provides:

> The Judges, both of the supreme and inferior Courts, shall hold their Offices during good Behaviour, and shall, at stated Times, receive for their Services, a Compensation, *which shall not be diminished during their Continuance in Office.*
> [Emphasis added.]

Perhaps there is merit for providing social security coverage, making social security benefits available to all of these individuals who have not had them, and providing credit for past service to Federal employees, Members of Congress, judges, the President, the Vice President, and all the other individuals who, under the Ways and Means Committee bill, would become eligible in 1982. The Committee, however, does not have a sufficient record on which to make a decision at this time with respect to coverage for those individuals under its sole jurisdiction (Federal employees) and it seriously doubts if there is sufficient record available to make such a decision at this time with respect to other individuals who will be brought into the system under the bill, as reported.

The report of the Committee on Ways and Means indicates that sufficient evidence is not available at the present time to properly determine whether social security coverage for these various groups of individuals is appropriate. That committee's report states as follows:

> Whether coverage should be extended to these specifically excepted groups is a complex question which your Commission (sic) has not been able to resolve in the time available.—(H. Rept. No. 95–702 Pt. 1, 95th Cong., 1st Sess. p. 34).

Similarly, that committee notes that although it has in the past directed studies concerning social security coverage for the Federal sector and that such studies were made in 1960, 1965, and 1972, "none of the proposals advanced has proved acceptable to all concerned" (H. Rept. No. 95–702 Pt. 1, *supra*, p. 35).

This committee in the brief time available has only been able to quickly review the hearings held by the Subcommittee on Social Security regarding this legislation. Perhaps a good case can be made for social security coverage for Federal employees, the President, the Vice President, Members of Congress, legislative employees, inmates of Federal penal institutions, certain student employees of Federal hospitals, and temporary emergency employees. Perhaps a good case cannot be made for coverage for all or some of these individuals. In any event, this committee believes that the issue should be studied before social security coverage and retroactive quarter-of-coverage credit for these different groups of individuals is mandated.

Previous experience on similar legislative issue

To illustrate the complexity of the proposition to integrate the benefits of the civil service retirement system with those of the social security system, it might be helpful to review a similar situation concerning the coordination of Medicare and the Federal Employees Health Benefits program.

The committee believes an analogy can be drawn between the unsuccessful attempt in 1972 to mandate coordination of Medicare and the Federal Employees Health Benefits program without the benefit of an adequate study to determine the feasibility of effecting such a change, and the attempt now in 1977 to integrate the benefits of the social security system with the civil service retirement system—the two largest retirement systems in the country—without a comprehensive study as contemplated by our committee amendment.

In 1972, the House Committee on Ways and Means adopted an amendment to H.R. 1 (Public Law 92–603, Social Security Amendments) providing that as of January 1. 1975, medicare payments would not be made for items and services covered under a beneficiary's Federal Employees Health Benefits Program plan unless, prior to that date, the Federal Employees Health Benefits program was modified to provide plans that supplement medicare coverage. The purpose of this provision was to focus attention on the need to consider improved coordination of Medicare and the Federal Employees Health Benefits program.

In the interim period (Oct. 30, 1972 to Jan. 1, 1975) full implementation of this requirement was to be accomplished. However, in 1974, because of the lack of progress toward coordination, the effective date was extended for another year to January 1, 1976 (Public Law 93-480). This law also provided for a joint progress report by the Department of Health, Education, and Welfare and the Civil Service Commission, to be submitted no later than March 1, 1975. This report, submitted on February 26, 1975, along with the recommendations of the General Accounting Office, outlined the problems of meeting the requirements of section 1862(c) of Public Law 92-603.

In the report, the Department of Health, Education, and Welfare and the Civil Service Commission maintained "that the modifications of Federal Employees Health Benefits Program in accordance with section 1862(c) would not be in the best interests of dually entitled Federal Employees Health Benefits and medicare beneficiaries, and would create expensive and unnecessary administrative problems." The reasons for this conclusion were expressed in a letter to Chairman David Henderson, House Committee on Post Office and Civil Service, from Secretary Casper Weinberger of the Department of Health, Education, and Welfare and Chairman Robert Hampton of the Civil Service Commission, as follows:

> The Civil Service Commission actuarial estimates are that if, as section 1862(c) implies, the premiums for the supplemental plans were based solely on the health experience of the aged and disabled who are entitled to medicare, rather than on the health experience of all Federal Employees Health Benefits enrollees, a Federal Employees Health Benefits option to [illegible] would offer the same benefits [illegible] to supplement [illegible] about the [illegible] to supplement [illegible] unnecessary, [illegible] individual has only part B [illegible] Federal Employees Health Benefits [illegible] to it.
>
> Section 1862(c) requires that the Government's full standard contribution to Federal Employees Health Benefits Coverage (as calculated annually under 5 U.S.C. 8906) be applied to pay the beneficiary's premium for the supplemental Federal Employees Health Benefits option, has part B premiums or both, but does not provide for crediting any portion of the Government Federal Employees Health Benefits contribution toward the premium of the employee's or annuitant's spouse (or [illegible] under a Federal Employees [illegible] but not under [illegible]
>
> T[illegible] each of the [illegible] Health [illegible] (b) [illegible] each for [illegible] (2) families [illegible] by medicare—making over [illegible] additional options. Thus, the Federal Employees Health Benefits Program would be greatly complicated.

The Comptroller General offered an alternative to achieve coordination which called for the Government to simply pay Medicare Part B premiums for all eligible Federal Employees Health Benefits enrollees. The Comptroller General's report also suggested continuation without change of the existing system for coordinating the benefits of the two programs.

After careful consideration of the various alternatives to coordinate the benefits under medicare and the Federal Employees Health Benefits program, the Committee on Ways and Means reported in 1975 that it "is not convinced that equity requires the Government to substantially increase its expenditures under the two programs in an effort to accomplish this."

The committee, therefore, concluded that the existing relationship between Medicare and the Federal Employees Health Benefits Program should be maintained. Public Law 94–182, repealed section 1862 (c) of the Social Security Act on December 31, 1975, bringing to a close this legislative adventure.

The idea of better coordinating the benefits of Medicare with those of the Federal Employees Health Benefits Program was useful, and obviously the House Committee on Ways and Means felt it could be done by the mandated date of January 1, 1975, which was over 2 years from the date of enactment. However, as this entire issue was more carefully studied by the Department of Health, Education, and Welfare and the Civil Service Commission, it became increasingly evident that no easy method could be found to implement the legislative mandate. The Congress, seeing the futility of this requirement of law, wisely repealed it rather than attempt the cumbersome and overly costly approach of amending the Medicare and the Federal Employees Health Benefits laws.

To avoid a recurrence of this type of legislative procedure, we strongly suggest a careful comprehensive study be undertaken to determine the feasibility of integrating the Civil Service Retirement System and the Social Security System before mandating such integration.

Conclusion

The issues related to mandatory social security coverage for Federal employees are complex and cannot be properly and rationally resolved without further study by both the Executive Branch and the Congress.

The Civil Service Commission, the Office of Management and Budget, and the Social Security Administration, must have time to develop and present a feasible plan to Congress on how these important policy, technical, and administrative problems can or should be resolved. Major changes in the civil service retirement system have always followed adequate congressional and administrative study. The Civil Service Retirement Act of 1920 followed a comprehensive study of the civil service retirement system and the means of financing the fund. The civil service retirement amendments of 1969 followed the report of the Cabinet Committee on Federal Staff Retirement Systems of 1966.

Thus, we must necessarily conclude that the time has not yet come for coverage under social security for Federal employees. We would wholeheartedly concur that the time has come to conduct a complete and comprehensive study of the issue. Upon completion of that study in 1980, as recommended by this committee, when we have found answers to the many important policy issues, to both the substantive and technical problems which must be resolved first, then the Congress can make a reasoned and accurate judgment on the question.

Anyone remotely familiar with the complexities of retirement systems understands that this study must necessarily be a condition precedent to any satisfactory integration of the different systems involved. To enact legislation disrupting the largest staff retirement system in the country without first laying a firm foundation for how the conversion can be made would be totally irresponsible.

ANALYSIS OF COMMITTEE AMENDMENT

The committee amendment strikes all of the provisions of section 301 of H.R. 9346, as reported by the Committee on Ways and Means, and substitutes an entirely new text for those provisions. Section 301, as reported by the Ways and Means Committee, provides for mandatory coverage of Federal employees within the old-age, survivors, and disability insurance system beginning in January 1982. The section also requires the Secretary of Health, Education, and Welfare, in consultation with the Civil Service Commission, to undertake a detailed study of how best to coordinate the benefits of the civil service retirement system and those of the social security system. In addition, section 301 calls for a study of how best to coordinate the Medicare program and the Federal Employees Health Benefits program. A report on the results of the two studies, together with a detailed plan for coordinating the benefits under the two systems, must be submitted to the Congress no later than January 1, 1980.

As amended by this committee, section 301 of H.R. 9346 does not provide for mandatory coverage of Federal employees under social security but requires that a comprehensive study concerning such coverage be undertaken and completed within two years after the date of the enactment of the legislation.

Specifically, subsection (a) of section 301 provides that the Chairman of the Civil Service Commission, the Secretaries of the Treasury and Health, Education, and Welfare, and the Director of the Office of Management and Budget, shall jointly conduct a detailed study with respect to the coverage of Federal employees under the old-age, survivors, and disability insurance system. The committee intentionally has refrained from designating a lead agency for purposes of the study and believes that the four agency heads are in the best position to decide which agency should have the overall responsibility for directing and coordinating the study.

Subsection (b) of section 301 sets forth specific matters which must be included in the joint study. (This listing should not preclude the consideration of other matters deemed appropriate by the four agency heads.)

First, paragraph (1) of subsection (b) provides that the joint study must include a review of the methods by which full coverage of Federal employees under social security could be attained. By "full coverage" this committee means coverage of all Federal employees for all purposes within the old-age, survivors, and disability insurance system. H.R. 9346, as reported by the Committee on Ways and Means, would mandate such full social security coverage for Federal employees beginning in 1982. This committee believes that the various methods of attaining such full coverage should be carefully explored so that the Congress will have a sound basis for determining whether full coverage of Federal employees is feasible and, if so, how can it best be effected.

For example, one method of accomplishing social security coverage of Federal employees might be to offset their Federal employee retirement system benefits when they become eligible for social security benefits. Another method might involve restructuring the various Federal employee retirement systems so as to supplement social security benefits.

Paragraph (2) of subsection (b) provides that for each method of attaining full coverage of Federal employees under social security the study must include an analysis of all of the adjustments which would be necessary to effect such coverage. This analysis must include not only the necessary adjustments to the social security system, but those that would be required for the civil service retirement system and the other principal Federal employee retirement systems that would be affected, such as the foreign service, the Central Intelligence Agency, the District of Columbia, and the system covering Federal judges.

In particular, the committee believes that the joint study should focus on the adjustments under each method that would be necessary in the age, service, and other eligibility requirements for benefits under the various systems. Among the Federal employee retirement systems and the social security system there is a wide variety of eligibility requirements for voluntary, involuntary and disability retirement, death benefits, and survivor benefits. (For example, some Federal employees may retire as early as age 50 if they have completed 20 years of service.) Subparagraph (A) of subsection (b)(2) requires an analysis of the necessary adjustments in eligibility requirements and subparagraph (B) requires a similar analysis of the adjustments that would be necessary in the nature and level of disability, death, and survivor benefits. This analysis should take into consideration all of the benefits which are provided under Federal employee disability and retirement systems, such as lump-sum refunds, cost-of-living adjustments, Federal employee compensation benefits, and related factors such as income limitations and the taxability of benefits.

Paragraph (3) of subsection (b) requires that the joint study include a comparison of the financial aspects of each method of attaining full social security coverage of Federal employees. Subparagraph (A) of paragraph (3) requires a comparison of the adjustments in contributions which would be required under each method. Federal employees under the civil service retirement system now contribute seven percent of their pay to the retirement fund. A matching contribution is made by the Government. Under H.R. 9346, the social security contribution rate also will reach seven percent by 1990. Can Federal employees be expected to fully contribute to both systems? The adjustments in such contribution rates and the sources of such contributions must be thoroughly considered in connection with each method of bringing Federal employees under social security.

Subparagraph (B) of paragraph (3) requires an analysis of the adjustments which would be required under each method in the manner in which benefits are financed under the various Federal employee retirement systems and under the social security system. Social security benefits are financed entirely by employer-employee contributions. Civil service retirement benefits are financed through a combination of contributions and appropriations. It will be important to know what adjustments in these financing methods will be necessary. Also, consideration must be given to the manner in which existing benefits for those who have already retired will continue to be financed.

Most significant is the requirement of subparagraph (C) of paragraph (3) that the joint study must include an analysis of the effects of each method of attaining full social security coverage on the solvency of the retirement systems involved.

Paragraph (4) of subsection (b) requires the joint study to include an analysis of the effects of each method of social security coverage for Federal employees on (A) the recruitment and retention of Federal employees; (B) other employee benefits, such as health benefits for retirees; and (C) Federal, State, and local income tax systems. The committee believes that all of these matters warrant careful consideration. The civil service retirement system, as well as most other employee retirement systems, has been carefully developed and improved over many years and plays a vital role in the recruitment and retention of competent workers. The Congress should know what effects any adjustments in civil service retirement benefits or other Federal employee retirement benefits will have on the recruitment and retention of talented people. Since social security beneficiaries are eligible for Medicare benefits, it would appear that some adjustments would have to be made in the Federal Employees Health Benefits program which covers most Federal retirees. The effects of social security coverage on this program and on any other Federal employee benefits program need to be studied. Finally, since civil service retirement benefits are fully taxable and social security benefits are not, any method of integrating or coordinating the two systems will most likely have a significant impact on Federal, State, and local income tax systems. The Congress should be aware of the magnitude of such impact before reaching a final decision on this subject.

Paragraph (5) of subsection (b) requires the joint study to include a review of the methods by which partial coverage of Federal employees under the social security system could be attained. Partial coverage would cover alternatives such as (1) extending social security coverage only to new Federal employees; (2) extending social security coverage only to certain classes of Federal employees; or (3) covering all Federal employees under the social security system but only for certain purposes, such as disability and survivors' benefits. In reviewing each method of partial coverage, paragraph (5) requires that consideration be given to all of the factors described in paragraphs (2), (3), and (4) of subsection (b), discussed above.

Paragraph (6) of subsection (b) provides that the joint study shall include a review of alternatives to providing coverage (either full or partial) of Federal employees under the social security system which would improve the solvency of that system. The committee believes that there may be ways of improving the financial status of the social security system other than by extending coverage to Federal employees. These alternatives must be considered in the event coverage of Federal employees proves to be infeasible.

Obviously, any decision to extend social security coverage to Federal employees will have a substantial impact on present employees, retirees, and on the various Federal employee retirement systems. Therefore, subsection (b) provides that in connection with the joint study, representatives of Federal employees and retirees and the heads of agencies which administer the various Federal employee retirement systems shall be allowed to submit views and data. In addition, other parties which have a significant interest in this matter should be allowed to submit their views and pertinent data.

Subsection (c) of section 301 provides that upon completion of the joint study (but in any event no later than two years after the enactment of the legislation) the four agency heads shall submit a joint report on the results of the study together with their recommendations. The report shall be submitted to the President and to the appropriate committees of each House of the Congress. As discussed above, subsection (b) requires a review of the various methods by which full coverage and partial coverage of Federal employees under social security could be attained. The report to be submitted under subsection (c) should include the detailed findings of the joint study with respect to each method of coverage and, particularly, the results of the analyses and comparisons required by paragraphs (2), (3), and (4) of subsection (b). Subsection (c) further provides that any recommendations included in the joint report shall be accompanied by draft legislation if such recommendations would require changes in existing statutes.

Subsection (d) of section 301 requires that the joint study conducted under subsection (b) and the joint report submitted under subsection (c) include at least one method of extending social security coverage to Federal employees which will result in a program of benefits that, overall, are no less favorable than the benefits which are then currently available to such employees under the Federal employee retirment systems. In addition, this method of coverage must assure that the contributions required of Federal employees will be no greater than the contributions then currently required of such employees under their Federal employee retirement systems.

The committee realizes that, in view of the many differences in benefits that exist between the Federal employee retirement systems and the social security system, it would be impossible to develop a method which extends social security coverage to Federal employees but, at the same time, preserves each and every benefit available to employees under the various Federal employee retirement systems. Such a matching of benefits is not intended by the committee under subsection (d). Rather, the committee contemplates a method of social security coverage which results in a package of retirement, disability and survivor benefits that, on the whole, compare favorably to those provided Federal employees under their existing retirement systems.

Subsection (e) of section 301 defines the term "Federal employee" for purposes of that section. The term is defined as meaning (1) an employee as defined in section 2105 of title 5, United States Code (which includes most officers nad employees appointed to positions in the three branches of the Federal Government); (2) an officer or employee of the Postal Service or of the Postal Rate Commission; and (3) any other individual in the employ of the United States or any instrumentality of the United States. As so defined, the term "Federal employee" is intended to cover any individual that has an employer-employee relationship with the United States or any instrumentality thereof.

The remaining committee amendments are conforming amendments necessitated by the committee amendment to section 301 of the bill.

COST

It is the view of the committee that the study and report which are required under its amendment to H.R. 9346 can be completed without any significant additional cost to the Government. In addition, the committee amendment makes no changes in existing law but merely continues existing law with respect to the exclusion of Federal employees from social security coverage. Accordingly, the enactment of the amendment to H.R. 9346, as proposed by this committee, should not result in any additional cost to the Government.

By letter of October 14, 1977, Chairman Nix requested that a cost estimate be furnished by the Congressional Budget Office pursuant to section 403 of the Congressional Budget Act. The short period of time allowed under the terms of the sequential referral, however, precluded the Congressional Budget Office from providing the requested cost estimate in time to be included in the committee report on H.R. 9346.

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON POST OFFICE AND CIVIL SERVICE,
Washington, D.C., October 14, 1977.

DR. ALICE M. RIVLIN,
Director, Congressional Budget Office, House of Representatives, Washington, D.C.

DEAR DR. RIVLIN: On October 13, 1977, our committee ordered reported H.R. 9346 ("Social Security Financing Amendments of 1977") with an amendment, a copy of which is enclosed.

The committee amendment strikes out those provisions of H.R. 9346, as reported by the Committee on Ways and Means, which would require mandatory social security coverage for Federal employees effective January 1982, and those provisions relating to a study by the Secretary of Health, Education, and Welfare.

In lieu of those provisions, our amendment calls for a joint study to be conducted by the Chairman of the Civil Service Commission, the Secretaries of the Treasury and Health, Education, and Welfare, and the Director of the Office of Management and Budget. Although the study is to be comprehensive, it is the view of this committee that the four agencies will be able to conduct the study with existing personnel and without any significant additional cost to the Government.

However, in accordance with section 403 of the Congressional Budget Act of 1974, I would appreciate your estimate of the costs, if any, which would be incurred in carrying out the provisions of the committee amendment.

Your staff may contact Bob Lockhart for any additional information relating to this matter.

Sincerely,

ROBERT N. C. NIX, *Chairman.*

Enclosures.

OVERSIGHT

Under the House rules the Committee on Post Office and Civil Service is vested with legislative and oversight jurisdiction of the subject matter covered by the committee amendment. The committee received no report of oversight findings or recommendations from the Committee on Government Operations pursuant to clause 4(c)(2) of House Rule X.

INFLATIONARY IMPACT STATEMENT

Pursuant to clause 2(l)(4) of House Rule XI the committee has concluded that the enactment of the committee amendment to H.R. 9346 will have no inflationary impact on the national economy. This conclusion is based on the fact that this committee's amendment to H.R. 9346, as reported by the Committee on Ways and Means, makes no change in existing law.

PERTINENT CORRESPONDENCE

Set forth below are the letters from Chairman Robert N. C. Nix to Chairman Al Ullman concerning this committee's concern with respect to H.R. 9346 and Chairman Nix's letters to the Speaker requesting sequential referral of H.R. 9346.

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON POST OFFICE AND CIVIL SERVICE,
Washington, D.C., September 29, 1977.

Hon. AL ULLMAN,
Chairman, Committee on Ways and Means, U.S. House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: Section 301 of H.R. 9346 extends the Social Security Act to employees of the United States who are covered by other Federal retirement systems effective December, 1979. Because the pay, fringe benefits, and employment policies of the Government generally for Federal employees come within the jurisdiction of the Committee on Post Office and Civil Service, I am writing to express my deep concern about the effect of this proposal as well as to state the committee's responsibility for jurisdiction over the issue.

Unless advocates of this proposal merely wish to provide more money for Federal employees during their retirement the apparent reasons for extending coverage to Federal employees would be to acquire the $43 billion assets of the Civil Service Retirement and Disability Fund (as of July 30, 1976) and to plan some future merger of the systems and reduce the combined benefits. I object on both grounds. First, the financial problems of the Social Security Fund would not be resolved by acquiring the assets of the Civil Service Retirement and disability Fund: along with the $43 billion assets, the retirement fund has an unfunded liability of $107 billion. Second, unlike social security, the Civil Service Retirement System is designed to sustain the purchasing power of a career Federal employee at a respectable level after 30 years of more of Federal service. Career staff retirement systems should not be combined with social security.

Current civilian pay exceeds $45 billion annually. Assuming a modest 6 percent increase in Federal salaries, the Government (employer) contribution to the Social Security Fund for Federal employees would require an additional budgetary outlay of at least $2.6 billion in 1980 if section 301 is approved. Federal employees, who now pay 7 percent of their gross salary for retirement benefits, would pay an additional 5.1 percent in 1980. An employee earning $12,000 a year would pay $1,440 or 12 percent of his total earnings, for social security and civil service retirement coverage.

Employees and employee organizations have expressed strong opposition to social security coverage at this time, and our committee has no plans to consider legislation combining civil service retirement with any other annuity program during the 95th Congress.

I would appreciate your making these views known to the committee members.

Sincerely,

ROBERT N. C. NIX, *Chairman.*

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON POST OFFICE AND CIVIL SERVICE,
Washington, D.C., October 4, 1977.

Hon. THOMAS P. O'NEILL, Jr.,
The Speaker, U.S. House of Representatives,
Washington, D.C.

DEAR MR. SPEAKER: The Committee on Ways and Means is presently considering, and expects to report this week, H.R. 9346, the Social Security Financing Amendments of 1977. Section 301 of that bill would extend coverage of the Social Security Act to Federal employees, effective December, 1981.

As you know, under House Rule X(o)(5) this committee has jurisdiction over all legislative matters relating to the "status of officers and employees of the United States, including their compensation, classification, and retirement". While it is argued that section 301 does not change or alter the existing civil service retirement system, and technically this is true, section 301, if enacted, would clearly require this committee to take some action to merge the civil service retirement system with the social security system. Failure of this committee to take some action prior to the 1982 "universal coverage" effective date would result in the absurd situation of Federal employees being covered by two separate (and totally unrelated) systems and would require both the Federal employee and the Federal Government to contribute to both systems.

I have detailed this committee's objections with respect to the merits of section 301 in a letter of September 29 to Chairman Ullman (copy encolsed). I think it is clear that section 301, although technically not amending or altering the civil service retirement system, does clearly and dramatically mandate changes in that system. Also, providing social security coverage for Federal employees in fact establishes a new retirement system, that is, social security, for those employees.

The Committee on Ways and Means has explicitly recognized that "universal coverage" will require changes in the civil service retirement law and has in fact provided for a Commission to study and report back in 1980 what changes are necessary. It seems to me that such an approach, that is, mandating a change and then attempting to find a means to accomplish the change is putting the cart before the horse.

Such matters are under the jurisdiction of this committee, and accordingly, should H.R. 9346 be reported with section 301 intact, I respectively request that it be sequentially referred to this committee for a period of time sufficient for this committee to consider the merits of that portion of the legislation which pertains to this committee's jurisdiction.

With kindest regards,

Sincerely,

ROBERT N. C. NIX, *Chairman.*

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON POST OFFICE AND CIVIL SERVICE,
Washington, D.C., October 5, 1977.

Hon. THOMAS P. O'NEILL, Jr.,
The Speaker, U.S. House of Representatives,
Washington, D.C.

DEAR MR. SPEAKER: This is in further reference to my letter of October 4 regarding H.R. 9346.

At a meeting of the caucus of the Democratic Members of the Post Office and Civil Service Committee held today, it was decided unanimously to send you this letter, cosigned by all the majority members of the committee, as well as most of the minority members, to urge you once again to sequentially refer H.R. 9346 to this committee.

We want to make it clear that it is not our intention to cause any delay in the timetable for consideration of this bill by the House. In this regard, we understand that the timeframe for a sequential referral would be governed by that fact. If it is necessary that the bill be considered in this session, thus permitting only limited time for referral, we assure you that we would act expeditiously. If, however, it is planned not to schedule this bill until the next session, we respectfully suggest a referral until early next January so that the committee can conduct hearings and follow the normal and orderly legislative process.

In any event, the committee is of the unanimous opinion that the action taken by the Ways and Means Committee, relating to mandatory social security coverage for Federal employees and integration of the civil service retirement and social security systems, grossly infringes upon a major portion of this committee's jurisdiction. The ramifications of section 301 of H.R. 9346 are of major and perhaps tragic proportions to Federal employees and the civil service retirement system, and such a matter should not be acted on by the House without full input by this committee.

If the committee structure in the House is to work as the House Rules intend it to, we believe it is imperative that the bill be sequentially referred to this Committee for appropriate action.

With kind personal regards,

Sincerely yours,

Robert N. S. Nix, Chairman; Pat Schroeder; Gladys Spellman; William L. Clay; Richard C. White; Bill Lehman; William D. Ford; Charles Wilson; Stephen Solarz; Mo Udall; Herbert E. Harris II; Leo J. Ryan; Jim Hanley; Ralph H. Metcalfe; Cee Hertel; Jim Howard; Michael O. Myers; Trent Lott; Jim Leach; Tom Corcoran; John H. Rousselot; Gene Taylor; Edward J. Derwinski.

Administration Views

Set forth below is a letter from the Chairman of the Civil Service Commission expressing the Administration's views with respect to H.R. 9346, and supporting the approach taken by this committee's amendment to that bill.

U.S. Civil Service Commission,
Washington, D.C.

Hon. Robert N. C. Nix,
Chairman, Committee on Post Office and Civil Service, House of Representatives, Washington, D.C.

Dear Mr. Chairman: The Civil Service Commission has carefully reviewed the action taken by the Ways and Means Committee to include in H.R. 9346, the "Social Security Financing Amendments of 1977," a provision which mandates social security coverage for Federal employees beginning January 1, 1982 and requires the Secretary, Health, Education, and Welfare in consultation with the Civil Service Commission to prepare a detailed study of methods for integrating the Civil Service Retirement system with social security by January 1, 1980. We are concerned about this provision as we believe that a step of this magnitude and complexity requires a thorough study of the benefits and financing of each system, full consideration of a range of methods for integrating the systems, and perhaps most importantly specific recommendations and proposals for a "phase-in" or transition period to protect the integrity of the systems and the equity of the individual's rights and benefits under each system.

While such a study is broader than that provided in H.R. 9346, we believe that it could be completed within the time frame required by the bill. We strongly believe that such a study is the necessary first step before establishing the timing of mandatory coverage.

We are not opposed to the concept of mandatory social security coverage for Federal employees. However, the Commissioners as trustees of the Civil Service Retirement Fund have, by law, an obligation to assure that contractual interests of current and former employees in the retirement fund are protected. Similarly the Commission believes we must have a total compensation package which enables the Government to attract and retain personnel.

We believe it is important that any changes in the Civil Service retirement system keep those objectives in mind.

The Office of Management and Budget advises that from the standpoint of the Administration's program there is no objection to the submission of this letter.

Please let us know if there is anything we can do to assist your committee's review of this important matter.

Sincerely yours,

ALAN K. CAMPBELL, *Chairman.*

CHANGES IN EXISTING LAW

Since the amendment proposed by this committee makes no changes in existing law, the requirements of clause 3 of House Rule XIII are inapplicable to this report.

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Calendar No. 526

95TH CONGRESS } SENATE { REPORT
1st Session } { No. 95–572

SOCIAL SECURITY AMENDMENTS OF 1977

REPORT

OF THE

COMMITTEE ON FINANCE
U.S. SENATE

ON

H.R. 5322

together with

MINORITY AND ADDITIONAL VIEWS

NOVEMBER 1 (legislative day, OCTOBER 29), 1977.—Ordered to be printed

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Calendar No.

95TH CONGRESS
1st Session
} SENATE {
REPORT
No. 95-572

SOCIAL SECURITY AMENDMENTS OF 1977

NOVEMBER 1 (legislative day, OCTOBER 29), 1977.—Ordered to be printed

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Mr. LONG, from the Committee on Finance, submitted the following

REPORT

together with

MINORITY AND ADDITIONAL VIEWS

[To accompany H.R. 5322]

The Committee on Finance, to which was referred the bill (H.R. 5322) to provide duty-free treatment for istle, having considered the same, reports favorably thereon with an amendment and an amendment to the title and recommends that the bill as amended do pass.

I. SUMMARY

The bill (H.R. 5322), as amended by the committee, would restore the social security programs of old-age, survivors, and disability insurance to financial soundness in both the short range and the long range, would increase the amount of earnings an individual can have without any reduction in social security benefits, and would make other modifications in the social security program as described below.

Social security financing

The committee bill includes several provisions designed to improve the financial status of the social security cash-benefits trust funds which, under present law, face serious deficit situations both over the long run and in the next several years. In combination, the financing provisions in the committee bill will result in a cash-benefits program which by 1990 will build up the trust fund balances to an acceptable level of 50 percent of 1 year's outgo. Over the traditional long-range actuarial valuation period of 75 years, the program has a favorable actuarial balance of +0.06 percent of taxable payroll under the committee amendments.

Revised benefit formula for future retirees.—A substantial part of the long-range social security deficit under present law results from unintended effects of the automatic cost-of-living increase mechanisms adopted in 1972. The committee bill makes the existing law cost-of-living increase provisions apply only to individuals who are already on the benefit rolls at the time each increase occurs. A new automatic adjustment mechanism will apply to the benefit formula for new retirees. This new formula will avoid the overindexing which was characteristic of the present-law formula. Under the new formula, persons retiring in the future will have their benefits determined on the basis of their previous wages after those wages have been adjusted to reflect changes in wage levels occurring after the wages were earned. This approach is generally referred to as wage indexing. The formula adopted is designed to maintain benefit levels as a percent of preretirement earnings at approximately the same ratio as applied in the case of persons who retired in 1976.

Increase in amount of earnings subject to employer tax.—Under existing law, the employer share of the social security payroll tax is collected on the first $16,500 earned by each employee. This amount increases automatically in future years as wages rise and is expected to increase to $17,700 in 1978. The committee bill would raise the base for employer taxes to $50,000 starting in 1979. The base will remain at $50,000 through 1984 and then increase to $75,000 in 1985. This amount would not be increased after 1979, as under present law, to reflect yearly increases in average wage levels. Instead, it will remain at $75,000 until early in the next century. Shortly after the turn of the century, the amount of annual earnings subject to the employee tax will have increased to $75,000 under the automatic increase provisions of present law. At that time, the employee and employer bases will again be equal. Thereafter, both bases will rise together as under present law when wage levels in the economy rise.

Increasing the amount of wages subject to social security taxes would also result in a similar increase under the railroad retirement program. Because railroad employers pay an additional tax of 9.5 percent which goes to support the part of the railroad retirement program that is essentially a staff retirement program, the committee bill provides that the 9.5-percent tax will continue to be paid on the same amount of earnings that would be taxed under present law while the increased employer tax base would apply only to that part of the employer tax rate which is equivalent to the social security tax rate.

Increase in amount of earnings subject to employee (or self-employed) tax.—In addition to increasing the amount of wages subject to the employer tax, the committee bill would increase the amount of annual earnings subject to the employee or self-employment tax. Under the provision, there will be four $600 increases over present-law levels in 1979, 1981, 1983, and 1985. As under existing law, the tax base for employees and self-employed persons will also be automatically increased as wage levels rise. The table below shows the projected tax bases under this amendment.

AMOUNT OF EARNINGS SUBJECT TO EMPLOYEE/SELF-EMPLOYED TAX

Years	Present law	Committee amendment
1978	$17,700	$17,700
1979	18,900	19,500
1980	20,400	21,000
1981	21,900	23,100
1982	23,400	24,600
1983	24,900	26,700
1984	26,400	28,200
1985	27,900	30,300

Tax rate increase.—The committee bill also modifies the social security tax rate schedules to bring in additional revenue. In order to bring in the revenue in a manner related to the projected outgo of the system, the modified tax rate schedule provides for a series of increases occurring in different years starting with 1979. The tax rate increases result in a revised tax rate schedule as shown in the table below. The changes in the hospital insurance (HI) rates shown in the table will, in combination with the tax base changes also included in the bill, leave the HI fund in close to the same position as it would be under existing law.

SOCIAL SECURITY TAX RATES ON EMPLOYER AND EMPLOYEE (EACH)

[In percent]

Years	Present law			Committee amendment		
	OASDI	HI	Total	OASDI	HI	Total
1977	4.95	0.90	5.85	4.95	0.90	5.85
1978	4.95	1.10	6.05	5.05	1.00	6.05
1979–80	4.95	1.10	6.05	5.085	1.05	6.135
1981–84	4.95	1.35	6.30	5.35	1.25	6.60
1985	4.95	1.35	6.30	5.65	1.35	7.00
1986–89	4.95	1.50	6.45	5.65	1.40	7.05
1990–94	4.95	1.50	6.45	6.10	1.40	7.50
1995–2000	4.95	1.50	6.45	6.70	1.40	8.10
2001–10	4.95	1.50	6.45	7.30	1.40	8.70
2011 and after	5.95	1.50	7.45	7.80	1.40	9.20

Increase in tax rate for self-employment.—When earnings from self-employment were made subject to the social security tax in 1950, the rate was set at 1½ times the employee rate. At that time the employee rate was 1.5 percent and the self-employment rate was 2.25 percent. Over the years as tax rates were increased, the 1½ to 1 ratio was maintained until 1973 when the cash-benefit tax rate for the self-employed was frozen at 7 percent. (When the hospital insurance program was established the self-employment rate for that program was made equal to the employee rate and has remained equal as the rate has increased.) The committee bill would restore the self-employment tax rate for cash benefits to the original ratio of 1½ times the employee rate effective in 1981.

Refund of taxes paid by State and local governments and by nonprofit organizations.—The bill would authorize an appropriation from general revenues to provide State and local governments and nonprofit organizations a partial refund of social security taxes. The refund would be equal to 50 percent of the difference between the employer social security tax paid with respect to an individual and the amount of tax paid by the employee.

Other social security provisions

Benefits for dependent spouses.—The committee bill would reduce benefits payable under social security to dependent spouses—including surviving spouses—by the amount of any civil service (Federal, State, or local) retirement benefit payable to the spouse. The provision would apply only to individuals applying for spouses' social security benefits in the future and only if the dependent spouse had a civil service pension based on his or her own earnings in public employment which was not covered under the social security system.

Modification of retirement test and financing of the provision.—Social security beneficiaries who are under age 72 have their benefits reduced if their earnings exceed a certain amount which is adjusted annually to reflect changes in average wage levels. The amount which may be earned with no reduction in benefits is $3,000 in 1977 and is expected to increase to $3,240 in 1978 and to $3,480 in 1979. The committee bill would increase these levels to $4,500 in 1978 and to $6,000 in 1979. After 1979, the $6,000 level would increase automatically as wage levels rise. (The 1978 increase would be applicable to the entire year but any additional benefits resulting from the change would not become payable until after September 30, 1978.) The committee bill would also increase the social security tax rate applicable to employers and employees, effective January 1, 1979, by the amount needed to fund the cost of the higher retirement test levels. These tax rate increases are incorporated in the tax schedule printed above.

Increased benefits for certain widows.—Social security benefits for individuals who continue working past age 65 are increased under present law by 1 percent for each year prior to age 72 that the worker did not receive his benefits. This delayed retirement increment which is added to the individual worker's benefit when he does retire or reach age 72 presently applies only to the worker's own benefit and is not passed through to his survivors. Under the committee bill, any such increment would also be added to the benefit payable to the widow or widower of such an individual.

Elimination of certain dual taxation requirements.—Under existing law, businesses are ordinarily required to pay social security taxes and Federal unemployment taxes with respect to a given employee only up to the amount of annual wages referred to as the tax base. (Under a provision described above, the tax base for the employer share of the social security tax would be increased to $50,000 effective in 1979 and to $75,000 in 1985. The base for Federal unemployment taxes is $6,000 after 1977.) Where a business is organized as a group of related corporations, however, an employee of any one of those corporations who performs services for more than one of them is treated for employment tax purposes as though he were employed by each of the corporations for which he performs services. Consequently, if his wages exceed the tax base, social security and unemployment taxes may be required to be paid in excess of the wage base. The employer share of these taxes over the wage base is not refunded. Under the committee bill, social security and unemployment taxes in excess of the tax base would not be paid in this type of situation starting in 1979.

Delivery of social security checks.—The committee bill would require timely delivery of social security checks when the normal delivery day falls on a weekend or legal holiday. Under present procedures, checks are generally delivered on the third of each month. In some cases when the third falls on a weekend or public holiday, the beneficiary may not receive—or may be unable to cash—the check until after the third. Under the committee bill, whenever the third of the month falls on a weekend or legal holiday, social security checks would be delivered on the Friday before the weekend—or on the day preceding the holiday. A similar rule would apply to checks under the supplemental security income (SSI) program which are ordinarily delivered on the first of the month.

Limitation on retroactive social security benefits.—Persons applying for social security benefits are now allowed to elect to receive benefits for up to 12 months prior to the month in which they file an application. If these months are months prior to age 65, however, the retroactive benefits are obtained at the cost of a lower permanent benefit amount since benefits paid before age 65 are actuarially reduced. Under the committee bill, retroactive reduced benefits generally would not be permitted in cases involving entitlement before age 65. This would create a short-range savings and reduce fiscal year 1978 costs by $0.3 billion.

Benefit increases as applied to reduced benefits.—Under the automatic cost-of-living benefit increase provisions, some persons on the rolls, through a technicality, receive an increase which is larger than the increase in the cost of living. This occurs because the percentage increase is applied not to the actual benefit amount but to the basic benefit rate (called "primary insurance amount") which represents what would be paid to a retired worker if he began drawing benefits at age 65. If an individual begins getting benefits prior to age 65 and therefore accepts an actuarially reduced benefit rate, subsequent benefit increases will be larger than is necessary to keep that benefit up to date with increases in the cost of living.

The committee bill would modify the cost-of-living increase mechanism so that all persons on the rolls at the time of an increase would receive the same percentage increase applied to their actual benefit amounts.

Study of spouse's benefits.—The committee bill would require the Secretary of Health, Education, and Welfare, in consultation with the Justice Department Task Force on Sex Discrimination, to study and report on proposals to eliminate dependency as a factor in the determination of entitlement to spouse's benefits under the social security program, and proposals to bring about equal treatment of men and women under the program, taking into account the practical effects (particularly the effect upon women's entitlement to such benefits) of such things as changes in the nature and extent of women's participation in the labor force, the increasing divorce rate, and the economic value of women's work in the home.

Study of consumer price index.—The committee bill also requires the Secretary of Labor, in consultation with the Secretary of Health, Education, and Welfare, to study the need to develop a special consumer price index for the elderly.

International social security agreements.—The committee bill would authorize the President to enter into agreements with other countries to coordinate the social security protection provided for people who work under the social security programs of the United States and another country. Agreements negotiated by the President would be submitted to Congress together with a report explaining their impact on program costs. If neither House passes a resolution of disapproval, the agreement could go into effect 90 days after the date of submission to Congress.

Nonprofit organization.—The committee bill contains provisions which would modify the provisions of Public Law 94-563 as it relates to the tax liabilities of certain nonprofit organizations which paid social security taxes without filing the waiver certificates required by the law and which under Public Law 94-563 are deemed to have filed such certificates.

Temporary administrative law judges.—The bill contains provisions which provide that certain temporary administrative law judges appointed to hear SSI claims some years ago will be appointed as regular administrative law judges in recognition of the experience they have had in the temporary positions.

Social security advisory council.—The committee bill extends the reporting date for the next Advisory Council on Social Security. Under existing law, the report is due to be filed by January 1, 1979. The committee amendment allows an additional 9 months (until October 1, 1979) for the completion of this report.

Welfare provisions

Fiscal relief for State and local welfare costs.—The committee bill provides $400 million in additional Federal funding of welfare costs as a means of providing fiscal relief to State and local governments for fiscal year 1978. Each State would receive a share of that total on the basis of a two-part formula. Half of the fiscal relief funds would be distributed to each State in proportion to its share of total expenditures under the program of aid to families with dependent children (AFDC) for December 1976, and half would be distributed under the general revenue sharing formula.

In some States, local units of government are responsible for meeting part of the costs of the AFDC program. The fiscal relief payments to those States under this provision would have to be passed through to local governments. However, States would not be required to pass through an amount in excess of 90 percent of the amount of the welfare costs for which the local government was otherwise responsible.

Quality control and incentives to reduce errors.—The committee amendment would establish a program of fiscal incentives as part of the AFDC quality control program to encourage States to reduce the level of their dollar error rates with respect to eligibility and overpayment, of aid paid under the approved State plan. Instead of applying sanctions on the States, the dollar error rates would be used as the basis for a system of incentives, which would give the States motivation for expanding their quality control efforts and improving program administration. Under the amendment, States which have dollar error rates of, or reduce their dollar error rates to, less than 4 percent but not more than 3.5 percent of the total expenditures would receive 10 percent of the Federal share of the money saved, as compared with the Federal costs at a 4-percent payment error rate. This percentage would increase proportionately as shown in the following table:

If the error rate is:	The State would retain this percent of the Federal savings
At least 3.5 percent but less than 4 percent	10
At least 3 percent but less than 3.5 percent	20
At least 2.5 percent but less than 3 percent	30
At least 2 percent but less than 2.5 percent	40
Less than 2 percent	50

Demonstration projects.—The committee bill broadens and makes more explicit the provision of present law relating to State demonstration programs. The objectives of the new demonstration authority would be to permit States to achieve more efficient and effective use of funds for public assistance, to reduce dependency, and to improve the living conditions and increase the incomes of persons who are on assistance—or who otherwise would be on assistance. These objectives would be achieved through experiments designed to make employment more attractive for welfare recipients.

This provision is similar in intent to an amendment approved by the Senate in 1973. It would limit States to not more than three demonstration projects. One of the projects could be statewide, and none of the projects could last for more than 2 years. The amendment would permit States to waive the requirements of the AFDC program relating to (1) statewideness; (2) administration by a single State agency; (3) the earned income disregard; and (4) the work incentive program. The State could request a waiver of any or all of these requirements on its own initiative. The waiver would be considered approved at the end of 45 days unless the Secretary disapproved it within this 45-day waiting period.

The provision would allow States to use welfare funds to pay part of the cost of public service employment, which would have to meet specified conditions. Participation in the demonstration projects would be voluntary. Costs of the projects would be eligible for the same matching as other AFDC costs, with the limitation that the amount matchable with respect to any participant in the project could not exceed the amount which would otherwise be payable to him under AFDC. Thus, it is estimated that the projects would not result in any increased Federal expenditures.

Access to wage information for AFDC verification.—The committee bill would improve the capacity of States to acquire accurate wage data by providing authority for the States to have access to earnings information in records maintained by the Social Security Administration and State employment security agencies. Such information would be obtained by a search of wage records conducted by the Social Security Administration or employment security agencies to identify the fact and amount of earnings and the identity of the employer in the case of individuals who were receiving AFDC at the time the earnings were received. The Secretary of Health, Education, and Welfare would be authorized to establish necessary safeguards against improper disclosure of the information. Beginning October 1979, the States would be required to request and use the earnings information made available to them under the committee amendment.

Earned income disregard.—Under present law States are required, in determining need for aid to families with dependent children, to disregard the first $30 earned monthly by an adult, plus one-third of additional earnings. Costs related to work—such as transportation, child care, uniforms, and other items—are also deducted from earnings in calculating the amount of the welfare benefit.

The committee bill requires States to disregard the first $60 earned monthly by an individual working full time—$30 in the case of an individual working part-time—plus one-third of the next $300 earned plus one-fifth of amounts earned above this. Child care expenses, subject to limitations prescribed by the Secretary, would be deducted before computing an individual's earned income. Other work expenses could not be deducted.

II. GENERAL DISCUSSION OF THE BILL

A. Social Security Financing

The need for legislation.—Over the years the committee and the Congress have devoted a considerable amount of time and effort to social security financing in order to assure that funds will be available to meet benefit payments as they fall due. Whenever benefit improvements have been enacted, the committee has recommended, and the Congress has provided, financing arrangements that, based on the best available economic and demographic assumptions, seemed to assure the financial soundness of the program over the long-range future.

The 1977 report of the Trustees of the social security trust funds showed for the fourth consecutive year that the social security cash benefits programs—old-age, survivors and disability insurance or OASDI—were inadequately financed in both the near-term and the long-range future. In addition, the hospital insurance program (HI) was described as being adequately financed over the next 5 years but with a tax rate schedule which would not finance the program over the long run.

It has been noted that the decline in the actuarial status of the trust funds began with the adoption of the automatic cost-of-living increases in benefits. While it is true that a substantial part of the long-term deficit is caused by the cost-of-living increases, this is because the assumptions made in 1972 as to future demographic changes and the relationship between rises in wage levels and increases in the CPI are now considered to have been excessively optimistic. As a result, the increases in wage levels have not paid (as was assumed in 1972) for the cost-of-living increases in benefits.

When the Congress last enacted major social security legislation, in 1973, the estimates of the cost of the cash-benefits programs were based on the assumption that the ultimate fertility rate would be 2.55 children per woman. By 1973, it was probably more reasonable to assume that the ultimate rate should be one which would approach zero population growth (about 2.1 children per woman). Subsequent cost estimates were based on lower fertility rates. The initial reduction came in 1974 when a rate of 2.1 was assumed and a further reduction was made in 1976 when an ultimate fertility rate of 1.9 was used for the 1976 assumptions.

As for the economic assumptions made for 1973, the most significant were that after 1977 average earnings would increase at an annual rate of 5 percent while the CPI would increase at 2¾ percent a year. Even at the end of 1973, this seemed a dim prospect, and the 1974 estimates were based on the assumption that the annual rise in the CPI would average 3 percent a year. The effect of this change, however, was offset to some degree by eliminating an 0.375 percent additional cost which had been included as a "safety factor" for years prior to 2011 in the 1973 estimates. By 1976, the assumptions had been changed to a 5.75 percent annual rise in average wages and a 4 percent annual rise in the CPI.

The long-range economic assumptions used for the 1977 estimates are basically those used for the 1976 estimates. Significant changes though, were made in the mortality and fertility assumptions. Mortality was assumed to improve, thus raising the cost of the program by 0.64 percent of taxable payroll. This increase in cost was offset by assuming that the fertility rate would rise to 2.1 (the approximate rate at which the population eventually would neither grow nor decline).

The committee bill.—In order to eliminate both the short-range deficits and the longer range deficit, the committee bill includes changes in the way benefits are computed, increases in social security tax rates for employees, employers, and the self-employed, increases in the contribution and benefit base for employees and the self-employed and for employers, and a reallocation of income between the disability insurance program and the other cash-benefits programs.

In the short term, 1978–87, the changes in the committee bill turn an estimated cumulative deficit for the OASDI program of $173 billion in 1987 into a positive balance of $102.5 billion. The added financing for the cash-benefits program also has a small impact on the funding of the medicare program. Table 1 shows the status of the trust funds over the next 10 years under existing law and under the committee bill.

TABLE 1.—STATUS OF SOCIAL SECURITY TRUST FUNDS UNDER PRESENT LAW AND COMMITTEE BILL

[Dollars in billions]

Year	Present law					Committee bill [1]				
	Income	Outgo	Net change	End of year fund	Start of year fund as percent of outgo in year	Income	Outgo	Net change	End of year fund	Start of year fund as percent of outgo in year
A. CASH BENEFITS PROGRAM										
1977	$82.1	$87.6	−$5.5	$35.6	47	$82.1	$87.6	−$5.5	$35.6	47
1978	90.7	97.6	−7.0	28.6	36	92.4	97.7	−5.4	30.2	36
1979	99.6	107.4	−7.8	20.8	27	108.0	108.1	−.1	30.1	28
1980	108.9	117.9	−9.0	11.8	18	119.6	118.5	1.0	31.3	25
1981	117.4	128.9	−11.5	.3	9	136.1	128.8	6.4	38.5	24
1982	125.2	140.1	−14.9	−14.6	(2)	147.1	139.1	8.0	46.4	28
1983	132.9	152.0	−19.2	−33.8	(2)	157.4	150.0	7.7	54.2	31
1984	140.7	165.1	−24.4	−58.2	(2)	168.5	161.9	6.6	60.8	33
1985	148.4	179.2	−30.8	−89.0	(2)	190.7	174.7	16.1	76.9	35
1986	156.2	194.4	−38.1	−127.2	(2)	205.3	188.2	17.1	93.9	41
1987	164.4	210.5	−46.1	−173.3	(2)	219.3	202.6	16.7	110.6	[4] 46

B. HOSPITAL INSURANCE PROGRAM

1977	$16.1	$16.2	−$0.1	$10.5	66	$16.1	$16.2	−$0.1	$10.5	66
1978	20.9	19.0	1.9	12.4	55	19.2	19.0	.2	10.7	55
1979	23.4	22.2	1.2	13.6	56	23.4	22.2	1.2	11.9	48
1980	25.6	25.7	−.1	13.4	53	25.9	25.7	.1	12.0	46
1981	33.2	29.7	3.6	17.0	45	32.7	29.7	3.0	15.0	40
1982	36.2	33.9	2.3	19.3	50	35.4	33.9	1.5	16.5	44
1983	38.6	38.5	.1	19.4	50	37.8	38.5	−.8	15.8	43
1984	41.0	43.7	−2.6	16.7	44	40.0	43.7	−3.7	12.1	36
1985	43.3	49.1	−5.9	10.9	34	45.6	49.1	−3.5	8.6	25
1986	50.2	54.9	−4.7	6.2	20	50.2	54.9	−4.7	3.8	16
1987	53.6	61.2	−7.6	−1.4	10	53.0	61.2	−8.2	−4.3	6

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[1] Includes committee decisions on both tax and benefit provisions. The committee has adopted the administration's estimate of the savings from the administration proposal regarding benefits for dependent spouses as the estimated savings from the related committee amendment offsetting government-employee pensions against such pensions.

[2] Less than $0.05 billion.

[3] Fund exhausted.

[4] Reaches 50% by 1990.

Over the long-range 75-year valuation period, estimates that seem reasonable at this time show that the amendments made by the committee bill would result in a small "actuarial" surplus of 0.6 percent of taxable payroll. As indicated in the actuarial section of this report, it is desirable for financing legislation to bring the program as close as possible to exact actuarial balance—leaving, if anything, a slight surplus as a margin of safety. The amendments proposed by the committee would achieve this objective.

In designing the financing scheme to reach this long-term objective of actuarial soundness, the committee also took into account the short-range financial needs of the system and the need to build the trust funds to a level where they would be able to sustain the programs should the Nation again be faced with adverse economic conditions such as those which prevailed for the middle part of this decade. Although the committee bill will not build the fund to the needed level (a balance which does not fall below an approximate 6 months expenditures) as quickly as the committee would wish, it does reach that level by 1990. The committee believes that this is a reasonable period within which to rebuild the reserves, and that a more rapid build-up would require tax increases of a level that could jeopardize continuing economic recovery.

THE TAX BASE

(Sections 101 and 102 of the Bill)

The employer tax base.—The traditional approach to financing the social security cash-benefits programs has been to levy an equal tax on employers and their employees. In considering how best to raise the funds necessary to the short-term financial soundness of the system without at the same time providing an intolerable tax burden either now or in the future, the committee, in a sense, determined to break with tradition by imposing a greater direct tax on employers than on employees. One reason for doing this is that social security benefits are based on individual earnings taxed and increases in the amount of employee earnings taxed raises additional income in the early years but over the long-term increases benefit costs so that much of the additional income is spent in later years. Employer taxes, on the other hand, do not increase the amount of earnings used to compute individual benefits. As a result, the additional income in the early years continues into the future without being offset by future benefit liabilities.

In deciding to increase the amount of earnings taxed to employers, the committee considered a number of levels (including taxing total payroll) and, with the aid of the actuaries, determined that the total package it had in mind could best be financed if the amount were to be increased to a maximum of $50,000 for each employee starting in 1979. The employer base would remain at $50,000 through 1984 and then would increase to $75,000 starting in 1985. There would be no automatic increases thereafter (as under present law) related to future increases in wage level until about the turn of the century when the employee and employer bases have both risen above $75,000. When the employee base does reach a level above $75,000, the two bases would once again be equal. Thereafter they would both rise together as wage levels in the economy increase.

The committee's decision to raise the employer base will affect the taxes paid by employers to support the Railroad Retirement program. The Railroad Retirement Act of 1974 provides a two-tier benefit with Tier-I providing what is essentially a social security benefit financed by an employer-employee tax that is tied to the social security tax base and tax rates. Tier-II, on the other hand, is financed by a 9.5 percent tax paid by employers only and on the same earnings taxed for Tier-I. Although the Railroad Retirement program is authorized by Federal law, financed by Federal taxes and administered by a Federal agency, the present provisions came about as the direct result of industrywide negotiations between management and labor. A basic part of the agreement resulting in the Railroad Retirement Act of 1974 was that employees would pay no more for the program than other employees pay for social security and that the cost of benefits above the level provided by the social security program would be paid for by management. The committee has been advised that railroad management and labor are now conducting industrywide negotiations on such issues as wages, conditions of employment and fringe benefits including Tier-II benefits. In order not to affect in any way these negotiations, the committee bill would increase the amount of earnings subject to employer taxes only with respect to the part of the railroad retirement tax equal to the social security tax. The additional tax of 9.5 percent would continue to be applied to the maximum amount of earnings that would be taxable under the provisions of present law without regard to the increases in the tax base that would be made by the committee bill.

Tax base for employees and the self-employed.—In addition to increasing the amount of wages subject to the employer tax, the committee bill would also provide a lesser increase in the amount of annual earnings subject to the employee or self-employment tax. Under the amendment, there will be four $600 increases above the levels which would exist under present law in 1979, 1981, 1983, and 1985. As under existing law, the tax base for employees and self-employed persons will also automatically increase as wage levels rise. The table below shows the projected tax bases under this amendment.

TABLE 2.—AMOUNT OF EARNINGS SUBJECT TO EMPLOYEE/SELF-EMPLOYED TAX

Years	Present law	Committee amendment
1978	$17,700	$17,700
1979	18,900	19,500
1980	20,400	21,000
1981	21,900	23,100
1982	23,400	24,600
1983	24,900	26,700
1984	26,400	28,200
1985	27,900	30.300

This amendment by itself would provide additional tax revenues for the program without increasing the tax burden on lower income workers. Only those workers earning in excess of the current base—some 15 percent of all covered workers—would pay higher social security taxes as a result of the increase in the base. Moreover, it permits the adoption of a lesser increase in tax rates (see below) than would otherwise be necessary to provide adequate financing.

Increasing the base in a decoupled social security system, as proposed by the committee, would result in a net long-range saving to the cash benefits program since the additional income resulting from raising the base is not completely offset by increased benefit rights resulting from larger amounts of workers' annual earnings being made creditable for benefits.

TAX RATES

(Section 103 of the Bill)

A significant part of the new funding (3.35 percent of taxable payroll or about $27 billion a year at present payroll levels in the long term) would be provided through increases in the social security tax rates paid by employers, employees and the self-employed.

Increase in self-employment tax rate.—When earnings from self-employment were made subject to the social security tax by the 1950 amendments, the rate was set at 1.5 times the employee rate. At that time the employee rate was 1.5 percent and the self-employment rate was 2.25 percent. Over the years as tax rates were increased, the 1.5 ratio was maintained until 1973 when the cash-benefits rate for the self-employed was frozen at 7 percent. (When the hospital insurance program was established the self-employment rate for that program was made equal to the employee rate and has remained equal as the HI rate has increased.)

Because a self-employed person gets the same protection that an employee with the same earnings gets under the program, there is a financial disadvantage to the program in covering the self-employed person, as compared to covering an employee, unless the self-employed person pays contributions at a rate as high as the combined employee-employer rate. On the other hand, though, looked at from the standpoint of an individual contributing toward his own protection, the self-employed individual could easily feel that he was being overcharged if he were required to pay social security contributions over a lifetime at the combined employee-employer rate. The self-employed rate of one and one-half times the employee rate that was established when the self-employed were first covered was a compromise between these alternatives.

The committee believes that the self-employed rate should be restored to its original level in relation to the employee rate and has included such a change in the bill. Based on the idea that protection under the HI program is the same for all workers, employees and the self-employed, the HI tax rate for the self-employed has in the past been the same rate as the employee rate. The committee would retain such treatment. The tax-rate schedule for the self-employed under present law and the committee bill is shown in table 3.

TABLE 3.—TAX RATES FOR THE SELF-EMPLOYED: PRESENT LAW AND COMMITTEE BILL

[In percent]

Years	OASDI		HI		Total	
	Present law	Committee bill	Present law	Committee bill	Present law	Committee bill
1977	7.00	7.00	0.90	0.90	7.90	7.90
1978	7.00	7.10	1.10	1.00	8.10	8.10
1979–80	7.00	7.05	1.10	1.05	8.10	8.10
1981–84	7.00	8.00	1.35	1.25	8.35	9.25
1985	7.00	8.50	1.35	1.35	8.35	9.85
1986–89	7.00	8.50	1.50	1.40	8.50	9.90
1990–94	7.00	9.15	1.50	1.40	8.50	10.55
1995–2000	7.00	10.05	1.50	1.40	8.50	11.45
2001–10	7.00	10.95	1.50	1.40	8.50	12.35
2011 and after	7.00	11.70	1.50	1.40	8.50	13.10

Tax rate increases.—In order to provide in an orderly way the revenue necessary to assure the short-term financial soundness of the cash-benefits programs, the committee bill contains (in additon to the increases in the tax base described above) a new schedule of tax rates. The new schedule was designed so that not only will the cash-benefits program be soundly financed, but the Hospital Insurance program (HI) will be in close to the same financial position that it would be under present law. This later point contrasts with some of the proposals presented to the committee which would have transferred substantial amounts of anticipated income from the HI program to the cash-benefits programs with the lost income being replaced with funds appropriated from general revenues or from unrealized savings from a suggested cost-reduction program which has not yet been enacted.

The new schedule calls for a series of tax rate increases starting in 1979 as shown in table 4.

TABLE 4.—SOCIAL SECURITY TAX RATES ON EMPLOYER AND EMPLOYEE (EACH)

[In percent]

Taxable Years	Present law OASDI	Present law HI	Present law Total	Committee amendment OASDI	Committee amendment HI	Committee amendment Total
1977	4.95	0.90	5.85	4.95	0.90	5.85
1978	4.95	1.10	6.05	5.05	1.00	6.05
1979–80	4.95	1.10	6.05	5.085	1.05	6.135
1981–84	4.95	1.35	6.30	5.35	1.25	6.60
1985	4.95	1.35	6.30	5.65	1.35	7.00
1986–89	4.95	1.50	6.45	5.65	1.40	7.05
1990–94	4.95	1.50	6.45	6.10	1.40	7.50
1995–2000	4.95	1.50	6.45	6.70	1.40	8.10
2001–10	4.95	1.50	6.45	7.30	1.40	8.70
2011 and after	5.95	1.50	7.45	7.80	1.40	9.20

Change in allocation to the disability insurance trust fund.—The committee bill would increase the allocation of tax income to the disability insurance trust fund so as to assure adequate funding and to take into account changing experience with the disability insurance program, the revision in the tax rates and the rise in the tax base. The present-law and proposed allocation schedules are shown in table 5.

TABLE 5.—ALLOCATION TO DISABILITY INSURANCE TRUST FUND

[In percent]

Calendar year	Employer and employee each: Present law	Employer and employee each: Committee bill	Self-employed rate: Present law	Self-employed rate: Committee bill
1977	0.575	0.575	0.815	0.815
1978	.600	.775	.850	1.090
1979–80	.600	.750	.850	1.040
1981–84	.650	.825	.920	1.2375
1985	.650	.950	.920	1.425
1986–89	.700	.950	.990	1.425
1990–94	.700	1.050	.990	1.575
1995–2000	.700	1.200	.990	1.800
2001–10	.700	1.350	.990	2.025
2011 and after	.850	1.500	1.000	2.250

PAYMENT TO NONPROFIT AND GOVERNMENTAL EMPLOYERS

(Section 106 of the Bill)

The committee bill, in order to provide adequate financing of the social security program, would significantly increase the amount of annual earnings subject to the employer social security tax. The committee is concerned over the potential immediate impact of this feature of the bill on nonprofit organizations and State and local governments. Private employers may be able to pass on in one manner or another the increased cost attributable to higher social security taxes. Moreover, to the extent that employers are unable to pass the impact of higher taxes on to consumers, they are able to claim the increased costs as a deduction against income in computing their income tax liability. In effect then, the net impact on an employer in the private profitmaking sector of an increase in social security taxes may be considerably less than the gross amount of those increased taxes.

In the case of nonprofit organizations and State and local governments, however, the situation is somewhat different. Frequently, these types of employers have virtually no capacity to pass on increased costs and, since they are not subject to Federal income taxes, they gain no increased deductions as a result of the higher taxes.

The committee generally believes that nonprofit organizations and State and local governments who have elected social security coverage should make the same payments into the system as other employers. However, since this bill provides an immediate substantial increase in employer liability, the committee believes that it would be appropriate and desirable to provide a reasonable amount of relief to these entities through a payment.

In order to provide this relief, the committee bill would authorize an appropriation from general revenues to finance such a payment.

DECOUPLING AND WAGE-INDEXED BENEFITS

(Sections 104, 105, and 107 of the Bill)

Automatic cost-of-living increases.—Existing law calls for automatic cost-of-living increases in benefits effective each June and for increases in the tax base (based on changes in wage levels) each January (assuming that the Consumer Price Index rises by at least 3 percent). Each benefit increase is put into effect by a revision of the table in the law. Thus, each increase applies not only to people entitled to benefits for the month the increase is effective but also to everyone who will become entitled to benefits in the future. For example, because of the rise in the CPI between the first quarter of 1976 and the first quarter of 1977, benefits for June 1977 were increased by 5.9 percent. As a result, each of the percentages in the benefit formula was increased by 5.9 percent. A further expansion of the table will take place in January when the maximum amount of earnings taxable rises to $17,700. Much of the estimated long-term deficit results from the fact that these modifications in the benefit formula apply to benefits which will be awarded in the future as well as to the benefits paid to people on the benefit rolls on the effective date.

Relationship between benefit formula and the deficit.—The automatic "cost-of-living" benefit increase mechanism incorporated into the social security program by the 1972 amendments, which had been recommended as a way to make benefits inflation proof, operates exactly as intended for persons on the benefit rolls. Once the initial benefit has been established, it is periodically increased by a percentage which restores its original purchasing power according to the official governmental index of purchasing power—the Consumer Price Index. The committee bill proposes no change in this concept.

The "cost-of-living" adjustment mechanism, however, also increases the percentages in the formula for determining initial benefits in the future. Future benefits however, are based on earnings which rise, in part, as the result of increases in prices. Thus, wages which were increased to take account of rising prices are multiplied by a benefit formula which was also increased to take account of the same increase in prices.

For an example of how benefits are increased under present procedures, assume a program with a benefit equal to 50 percent of wages. In such a program wages of $100 would produce a benefit of $50. If wages and prices both rise by 10 percent, the individual who is on the benefit rolls will have his benefit increased to $55 and the person who is still working will have his $100 wage increased to $110. If the benefit formula is left unchanged, both individuals would qualify for a $55 benefit. But under present procedures the benefit formula is also increased to 55 percent and the person who will retire in the future with wages increased from $100 to $110 will get a benefit of $60.50.

Under any reasonable projection of future economic conditions, benefit levels determined by the present-law mechanism will be much higher than what is necessary to simply adjust for inflation and will represent an ever-increasing percentage of the new retiree's wages in the year before he retires. For significant numbers of people, the benefits payable just after retirement would approach—and in many cases exceed—their wage levels immediately before retirement. It is this part of the current cost-of-living provisions that the committee bill would change as discussed below.

The starting point for most proposals for dealing with the current long-term deficit of the social security system is a concept called "decoupling." Decoupling means that the automatic benefit increase mechanism in present law would continue to apply to keep benefits inflation proof after a person retires and begins to draw his benefits but the formula for determining benefits at the time of retirement would no longer be automatically increased. If the system were simply decoupled with no other changes, an individual retiring in 1987 would get the same initial benefit as a man or woman with the same average earnings retiring in 1977. The level of initial benefits would tend to grow in the future but only as a result of rising wage levels which, using the same benefit formula, would tend to generate higher benefits. However, the rise in actual benefits awarded in the future would not be enough to keep pace with the anticipated rise in wage levels or to offset the expected rise in the CPI.

Decoupling by itself would make a substantial reduction in the long-term cost of the program but would also cause a significant reduction in the real value of future benefits. In order to forestall a reduction of this nature, the committee bill would provide a new automatic mechanism for adjusting the formula for computing initial benefits which is designed to keep replacement rates at about existing levels. This proposal, in slightly different form, was recommended by the 1974 Advisory Council on Social Security. The committee has been advised that the method adopted in its bill would assure future benefits at approximately the level of the benefits provided last year.

Under the committee bill, indexed earnings would be averaged and a three-step, weighted benefit formula would be applied to the individual's average indexed monthly earnings (AIME) to produce the benefit amount. For those becoming entitled to benefits in the future, the benefit factors (percentage amounts) would not be indexed, but the bend points (dollar amounts) in the formula would be adjusted automatically as average wages increase.

Under the benefit procedures included in the committee bill, the relationship between the benefits paid at the time of retirement and earnings in the year prior to retirement is expected to be a constant 43 percent for a person retiring at age 65 with earnings in all years equal to the national average, and the real value of benefits expressed in terms of 1977 prices will rise three times by the year 2050.

A basic change such as that which would be provided by the committee bill also requires many substantial changes in provisions of present law, transitional provisions for the period during which the new system is implemented, and a number of conforming amendments to minimize the possible disruptions that so basic a change in the benefit structure might otherwise produce.

Wage indexed earnings.—The committee's bill would provide that an individual's benefit be based on the earnings level that prevails just prior to age 62, disability, or death. To do this, an individual's earnings in each year after 1950 would be updated (indexed) to reflect the increase in average wages through the second year before an individual reaches age 62, becomes disabled, or dies.[1] (Under present law, for the purpose of computing a benefit, earnings are counted in actual dollar value, and these earnings do not reflect their value relative to average earnings at the time they were earned.)

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[1] While it would seem reasonable to update earnings through the first year before the year one reaches retirement age, the Social Security Administration informed the committee that data on actual wage growth will not be available in time to allow for such current indexing. For 1978 and subsequent years, the law provides that earnings will be reported on an annual rather than a quarterly basis. Thus, for example, data on average wage levels in 1980 will not become available until late in 1981—too late for indexing earnings of workers who reach age 62, become disabled, or die in 1981; 1979 would be the indexing year for such workers.

TABLE 6.—BENEFITS, REPLACEMENT RATES AND EXPENDITURES UNDER PRESENT PROGRAM 1955–2050

[In percent]

	Worker with average earnings[1]		Replacement rate for worker with—		Aggregate OASDI expenditures	
Year	Annual benefit in 1977 prices	Replacement rate	Low earnings[2]	High earnings[3]	As percent of payroll	As percent of GNP[4]
1955..	$2,141	31	45	31	3.34	1.3
1960..	2,493	33	45	30	5.89	2.3
1965..	2,665	32	43	33	7.93	2.8
1970..	2,987	34	46	29	8.12	3.4
1975..	3,619	43	56	30	10.65	4.6
1979..	4,444	46	58	35	10.85	4.5
1985..	5,354	48	60	34	11.56	4.8
1990..	5,871	49	63	36	12.39	5.1
1995..	6,476	49	66	37	13.13	5.4
2000..	7,406	52	75	39	13.92	5.7
2010..	9,489	56	84	42	16.57	6.8
2020..	11,916	60	91	44	21.64	8.9
2030..	14,765	63	96	46	26.02	10.7
2040..	18,122	65	101	47	26.67	11.0
2050..	22,088	67	106	48	26.93	11.1

	Percent
Average medium-range cost (1977–2001)	12.24
Average medium-range revenue	9.90
Average medium-range balance	−2.34
Average long-range cost (1977–2051)	19.19
Average long-range revenue	10.99
Average long-range balance	−8.20

[1] Assumed to be 4 times the average 1st quarter covered earnings.

[2] Assumed at $4,600 in 1976 and following the trends of the average.

[3] Assumed at the maximum taxable under the program.

[4] For 1979 and later, based on full employment and assuming taxable payroll equals 41.1 percent of GNP.

Note: The estimates in this table are based on the economic and demographic assumptions used in the intermediate cost estimates (alternative II) in the 1977 OASDI Trustees Report. The replacement rates pertain to workers with steady employment at increasing earnings and compare the annual retirement benefit at age 65 with the earnings in the year immediately prior to retirement.

TABLE 7.—BENEFITS, REPLACEMENT RATES, AND EXPENDITURES UNDER COMMITTEE BILL, 1979–2050

[In percent]

	Worker with average earnings [1]		Replacement rate for worker with—		Aggregate OASDI expenditures	
Year	Annual benefit in 1977 prices	Replacement rate	Low earnings [2]	High earnings [3]	As percent of payroll	As percent of GNP [4]
1979..	[5] $4,444	[5] 46	[5] 58	[5] 35	10.29	4.2
1985..	4,713	43	54	30	10.56	4.3
1990..	5,145	43	55	29	10.84	4.4
1995..	5,581	43	54	30	11.29	4.5
2000..	6,068	43	54	31	11.68	4.6
2010..	7,172	43	54	32	12.88	5.0
2020..	8,472	43	54	32	15.72	6.1
2030..	10,011	43	54	32	17.86	7.0
2040..	11,830	43	54	32	17.36	6.8
2050..	13,978	43	54	32	16.81	6.6

	Percent
Average medium-range cost (1977–2001)	10.93
Average medium-range revenue	11.83
Average medium-range balance	+.90
Average long-range cost (1977–2051)	14.16
Average long-range revenue	14.22
Average long-range balance	+.06

[1] Assumed to be 4 times the average 1st quarter covered earnings.

[2] Assumed at $4,600 in 1976 and following the trends of the average.

[3] Assumed at the maximum taxable under the program.

[4] Based on full employment and assuming taxable payroll equals 41.1 percent of GNP.

[5] Based on the present law benefit formula for all workers attaining age 62 before Jan. 1, 1979.

Note: The estimates in this table are based on the economic and demographic assumptions used in the intermediate cost estimates (alternative II) in the 1977 OASDI Trustees Report. The replacement rates pertain to workers with steady employment at increasing earnings and compare the annual retirement benefit at age 65 with the earnings in the year immediately prior to retirement.

Earnings would be indexed by multiplying the actual earnings by the ratio of average wages in the second year before an individual reaches age 62, becomes disabled, or dies to the average wages in the year being updated. For example, if an individual earned $3,000 in 1956, and retired at age 62 in 1979, the $3,000 would be multiplied by the ratio of average annual wages in 1977 (estimated to be $10,002) to average wages in 1956 ($3,514), as follows:

$$\$3{,}000 \times \frac{\$10{,}002}{\$3{,}514} = \$8{,}539$$

Thus, while the actual earnings for 1956 were $3,000, the relative or indexed earnings would be $8,539. Earnings each year would be adjusted in this manner. The result would be that an individual's benefits would be based on the earnings level that prevails at age 60 and benefits would be based on the individual's relative earnings (that is relative to average wages) averaged over the time most people could reasonably be expected to have worked in covered employment.

The committee understands that as part of this change, the Secretary of Health, Education, and Welfare recommends that the method of computing average wages nationally be changed from the present procedures which rely on earnings reported for social security purposes to a system which would be based on wages reported for Federal income tax purposes. The change is needed because the social security law provides for combined annual reporting of wages for social security and income tax purposes beginning in 1978. The committee bill would authorize such a change. Average wages would be equal to the sum of wages subject to income taxes or social security taxes as reported to the Internal Revenue Service, and divided by the number of individuals reported on the withholding statements. For 1977 and 1978, form 1040 data would be used and after 1978, forms W–2 data would be used. Adjustments in earlier data would be made to allow for overall comparability.

The change in the way benefits are computed proposed by the committee bill would also reduce the increasing advantage that young disabled people and their families and the survivors of deceased individuals have over retired workers under present law. Under the present method of computing benefit amounts, benefits for young disability and survivor cases are based on recent and relatively high earnings while benefits for new retirees are based on an average that is depressed because of past earnings levels that are generally much lower than current earnings levels. In certain cases, the difference in benefit amounts can be substantial.

Base year for indexing.—The committee's bill would index earnings in retirement cases through the second year before age 62 (the age of first eligibility) rather than to retirement (when an individual is first entitled to benefits). Because the indexing point is based solely on the date of birth rather than on the year retirement benefits are elected, people would be assured that their age-62 benefit would not decline if average wages declined and that it would rise should the Consumer Price Index rise. If wages were indexed to the date of retirement instead of to age 62, the worker's benefit amount could decline after the date he could first have been eligible if average wages decline.

Computation period.—The committee bill, like present law, would provide that benefits generally would be based on earnings averaged over the number of years after 1950 (or age 21, if later) up to the year an individual reaches age 62, becomes disabled, or dies, whichever occurs first (excluding 5 years of lowest earnings). The number of years in the computation period would expand over time—for example, for an individual reaching age 62 in 1979, the computation period would be 23 years, and eventually, for individuals reaching age 62 in 1991 or later, the computation period would be 35 years.

With the use of actual earnings, as under present law, the expanding computation period would depress replacement rates since early wages, which are generally much lower than current wage levels, must be used in computing the benefits. However, wage indexing is designed so that if an individual's earnings increase at the same rate as average wages in the economy, average indexed monthly earnings (AIME) rise at the same rate as average wages in the economy.

Benefit formula.—Under present law, benefit amounts for an individual are derived from a table in the social security law and are related to the average monthly earnings in covered employment. The benefit formula that roughly approximates the benefit amounts shown in the table in present law has nine steps and, whenever the tax base is increased, a new step is added to take account of the higher average earnings possible as a result of the new, higher base. Each time there is an automatic cost-of-living benefit increase, the percentage factors in the formula are increased by the percentage increase in the cost of living.

Under the committee's bill, the benefit formula shown below would be applied to an individual's average indexed monthly earnings (AIME). The formula is designed to produce benefits which are approximately equal to the benefits that were payable under present law to workers retiring in 1976:

92 percent of the first $180 of AIME; plus
33 percent of AIME over $180 through AIME of $1,075; plus
16 percent of AIME above $1,075.

This formula would apply to those who reach age 62, become disabled, or die in 1979. The dollar amounts or bend points (the AIME levels at which the weighting in the benefit formula changes) would be adjusted automatically as average wages increase for those who become eligible for benefits in the future, and the adjusted bend points would be rounded to the nearest multiple of $1. After the individual benefit has been established in this way it would be increased as provided by the automatic cost-of-living provisions.

Maximum family benefit.—Under present law, the maximum family benefit ranges from 150 percent to 188 percent of the primary insurance amount (PIA).[2]

The committee bill retains the same relationship between maximum family benefits and PIA's as in present law and to accomplish this would determine the family maximum (in 1979) by applying the following formula to the worker's PIA:

150 percent of the first $236 of PIA, plus
272 percent of the next $106 of PIA, plus
134 percent of the next $107 of PIA, plus
175 percent of the remainder.

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[2] The amount on which all benefits are based.

In the future, the dollar amounts in the formula would be increased based on increases in average wages. This would assure that the same relationship between maximum family benefits and PIA's would be maintained. Once the family maximum has been established in an individual case, the maximum payable to the family would be increased by the same percentage that benefits are increased under the automatic cost-of-living provisions.

Transition.—Because the committee bill would provide benefits that would be about equal to those payable under present law in 1976, a transitional provision has been included to protect the benefit rights of people who are now approaching retirement and whose retirement plans have taken social security benefits into account.

Under the committee bill, the transitional provision would guarantee that an individual who first becomes eligible for retirement benefits within 5 years after the effective date would get an initial benefit that would be the higher of: (a) The benefit derived under the new benefit formula; or (b) the benefit based on the present law benefit table as it is in the law on the effective date of the revised system—January 1979.

For purposes of the guarantee, the January 1979 benefit table would not be subject to future automatic benefit increases, but all individual benefits would be subject to all benefit increases that become effective after age 62. Earnings after age 61 would not be used under the guaranteed benefit computation. With the passage of time, benefits under the wage-indexing system would rise beyond the levels generally payable under the guarantee, because future wage increases would be reflected in a higher AIME and in the adjustments in the benefit formula each year. As a result, the proportion of new retirees that would receive higher benefits under the guarantee would decrease with each passing year.

The committee bill would not provide a similar transition for death and disability cases because these benefits under present law can be significantly higher than in retirement cases for similar earnings histories.

Treatment of earnings after age 62 or disability.—Under the committee bill, earnings subsequent to the year of first eligibility (age 62) or onset of disability would be counted at actual dollar value (that is, they would not be indexed). They would be substituted for earlier years of indexed earnings in the initial computation or recomputation if they would increase a worker's AIME and his PIA. These provisions are similar to those under present law. However, because past earnings would be higher after wage indexing than under present law, earnings after retirement can be expected to have substantially less effect in increasing benefit amounts than they have under present law.

Special rules would apply in the case of earnings after age 61 during the transitional period. People who are eligible for benefits under the transitional guarantee (because they reached age 62 in the period from 1979 through 1983) could have earnings after age 61 included only under the wage-indexing computation. Earnings after age 61, however, could not be included in the computation of guaranteed benefits under the transitional provision.

Those age 62 or disabled before 1979 would continue to have their benefits computed and recomputed under the provisions of present law even if they work in covered employment after 1978.

Treatment of earnings before 1951.—Under the committee bill, earnings before 1951 would not be indexed and could not be used in computing benefits under the new wage-indexing system. Instead, the present-law computation method that applies in the case of pre-1951 earnings would be used; this present-law computation provides for allocating total pre-1951 earnings according to a formula designed to avoid time-consuming manual procedures that would otherwise be necessary, due to the fact that the Social Security Administration does not have a year-by-year breakdown of pre-1951 earnings on machine records.

Under the bill a nonprofit organization or a State or local government which is covered under social security would be eligible for a payment subject to the availability of appropriations, this payment would be equivalent to 50 percent of the employer tax liability to the extent that that liability exceeds the tax liability of the persons it employs. This provision gives nonprofit organizations and State and local governments an amount of relief related to the higher employer wage base approximately equivalent to the value of an income tax deduction for a profitmaking private employer. The provision would be effective in 1979 since this is the first year in which the employer tax base would be higher than the employee tax base.

The provision is designed to provide relief in a manner closely related to that element of the financing package which will create an immediate and substantial increase in social security costs for State and local governments and non-profit organizations. It is a transitional provision which will phase out as the employee base rises in the future.

Cost of the provision.—The provision is estimated to cost $83 million in fiscal year 1979.

B. OTHER PROVISIONS

THE RETIREMENT TEST

(Section 121 of the Bill)

Under the present law, the benefits paid are reduced whenever an individual under age 72 has significant earnings. Although a test of retirement has been in the law since the original law was enacted in 1935, the provision has generated a great deal of discussion and argument. While most people seem to believe that some test of retirement is appropriate to the program, there is little agreement as to what the appropriate test should be. Others believe that the concept of the social security program as an income replacement program is not appropriate and that the basic nature of the program should be changed so that it would provide benefits without regard to continued earnings activity.

The committee considered these various concepts and determined that the better course would be to continue the program, as currently conceived, in the income replacement tradition. The committee notes that in the first year an annuity program would cost some $6 to $7 billion if payments were to be made to all beneficiaries, regardless of age. While this cost could be substantially reduced by making benefits available as an annuity only at age 65, the committee believes it is preferable to continue the practice of making the same retirement test applicable to all persons under age 72.

At the same time, the committee is aware that the present level of benefits can be inadequate in many individual circumstances. The committee, therefore, recommends that the law be changed to provide a substantial increase in the amount of money an individual can earn and still receive all of his benefits while at the same time retaining the basic concept of the cash-benefits program as an income replacement program. In keeping with this decision, the committee bill would increase the amount an individual can earn without any reduction in benefits to $4,500 in 1978 and to $6,000 in 1979. As under present law, earnings above that amount would result in a $1 reduction in benefits for each $2 earned above $4,500 in 1978 and above $6,000 in 1979, with automatic increases in these amounts in future years as average earnings rise. There would be no reduction in benefits for any month in 1978 in which an individual earned less than $375 and did not render substantial services in self-employment or for any month in 1979 in which an individual earned less than $500 and did not render substantial servinces in self-employment. Under the committee amendment, an individual who has a 1978 benefit of $300 a month would not lose all of his benefits until he had earned $11,700 and in 1979 until he had earned $13,200.

The committee is aware that in the past there has been a tendency to use the retirement test exempt amount as a guide in setting the earnings level used as a presumption that a disabled individual can engage in substantial gainful activity. While the committee believes that this was appropriate in the past when the retirement test exempt amount was relatively small, the larger exempt amount resulting from the committee decision is not intended as a measure of an individual's ability or inability to engage in substantial gainful activities. The committee suggests that the Secretary of Health, Education, and Welfare devise a more appropriate measure of earnings to use in determining an individual's ability to engage in substantial gainful activities.

To avoid any budgetary impact in fiscal year 1978, the committee bill provides that, while the provision will be effective for all of 1978, no monthly payments, other than the payments which would be made under present law, would be permitted until October 1, 1978.

The provision will substantially increase benefit payments in fiscal years after 1978. The committee, in adopting this provision, specifically increased the social security tax rates by the amount necessary to generate offetting revenues. Thus, from the standpoint of long-range financial soundness of the program, the provision is fully funded.

Costs and number of people affected.—About 1.8 million people would be paid benefits or would be paid larger benefits in 1979. About $2 billion in additional benefits would be paid in 1979.

Effective date.—The provision would become effective as of October 1, 1978, with respect to benefits payable for months after December 1977.

INCREASED BENEFITS FOR CERTAIN SPOUSES

(Section 122 of the Bill)

Under present law, a worker who continues working and delays retirement beyond age 65 gets a delayed retirement credit of one-twelfth of 1 percent of his benefit for each month (1 percent a year) for which he does not receive a benefit from age 65 up to the earlier of the month he retires or reaches age 72. The credit is applied to the worker's benefit only and does not affect the benefits of dependents and survivors.

Under the committee bill, the delayed retirement credit earned by an individual would be added to the surviving spouse's benefit. Specifically, the percentage increase in the individual's retirement benefit due to the delayed retirement credit (or the increase that would have been provided had the individual retired at the time of death), would be added to the surviving spouse's benefit.

To the extent that the delayed retirement credit is provided in consideration of the worker's post-age 65 earnings (and taxes) the committee believes that the surviving spouse's benefit—which is based on total earnings (including post-65 earnings)—should also include any delayed retirement credit earned by the worker.

Costs and number of people affected.—About 40,000 people would become eligible for benefits or would become eligible for larger benefits on the effective date. About $4 million in additional benefits would be paid in the first full year.

Effective date.—The provision would become effective with respect to benefits payable for months after December 1977.

OFFSET OF BENEFITS OF SPOUSES RECEIVING PUBLIC PENSIONS

(Section 123 of the Bill)

Under present law, a woman can become entitled to spouse's or surviving spouse's benefits without proving dependency on her husband. As a result of a March 1977 Supreme Court decision, a man can also become entitled to spouse's or surviving spouse's benefits without proving his dependency on his wife. (In *Califano* v. *Goldfarb*, the court ruled that men should be treated equally with women in determining entitlement for surviving spouse's benefits. Subsequently, other court decisions extended this ruling to husband's benefits. Previously, a man had been required to prove his dependency on his wife to become entitled to spouse's or surviving spouse's benefits, although women were presumed dependent.) Under the social security program, an individual who is entitled to two benefits does not receive the full amount of both benefits. For example, if one is entitled to both a worker's benefit and a spouse's benefit, the full worker's benefit is paid first and then the amount (if any) by which the spouse's benefits exceed the worker's benefit. This "dual-entitlement" provision prevents payment of dependents benefits to some persons not truly dependent. However, persons who receive civil service pensions based on their work in noncovered employment and are entitled to social security spouses' benefits, receive their dependent spouses' benefits in full, regardless of their dependency on the worker. This results in "windfall" benefits to some retired government employees.

The committee recommends that social security benefits payable to spouses and surviving spouses be reduced by the amount of any public (Federal, State, or local) retirement benefit payable to the spouse. The offset would apply only to pension payments based on the spouse's own work in public employment which is not covered under social security. In general, this should assure that dependents' social security benefits will not be paid to persons not dependent on the worker.

Consideration was given to requiring claimants to prove their dependency on the worker before entitling them to spouses' benefits. However, a dependency test would be subject to manipulation. For example, a government employee with earnings higher than those of his wife could qualify for a social security spouse's benefit by allowing a few months to intervene between the date of his retirement and the effective date of his pension. Also, a dependency test could deny spouses' benefits in situations where it would seem undesirable to deny such benefits. For example, a woman might, in fact, be dependent upon her husband for most of her life and might have earned little or nothing in the way of retirement income protection in her own right and yet be denied benefits if a dependency test were implemented. This could occur if her husband became ill shortly before reaching retirement age, thus forcing a temporary reversal of their usual dependency situation. Additionally, a dependency test would require substantial numbers of persons to provide information with regard to their total income in order to establish entitlement, a significant departure from present practice where income is not generally a factor in entitlement. Making such determinations would also create administrative difficulties. For these reasons, the committee believes an offset is preferable to a dependency test. The provision would be applicable only to future beneficiaries.

Costs and number of people affected.—About 85,000 people would be affected by the provision during the first year. The provision is estimated to save $190 million in 1979.

Effective date.—The provision would become effective with respect to benefits payable for months starting with the month of enactment on the basis of applications filed in or after the month of enactment.

ELIMINATION OF CERTAIN DUAL TAXATION PROVISIONS

(Section 124 of the Bill)

The committee bill contains provision for limiting employer social security and unemployment insurance tax liability in certain instances of concurrent employment of workers by related corporations. Present law requires each employer to pay social security and unemployment insurance taxes on the wages an employee receives because of his employment by that employer, up to the taxable earnings base ($16,500 for social security purposes and $4,200 for unemployment insurance purposes in 1977). If an employee has covered wages from more than one employer, each employer is liable for employer social security (and unemployment) tax on wages up to the maximum amount of earnings taxable for the year. In the case of concurrent employment by two or more related corporations, each of the employing corporations is liable for social security (and unemployment) taxes on that part of the worker's wages attributable to services performed for each employer. Thus, in such cases of concurrent employment involving high-paid workers, two or more employers may be liable for employer taxes on an employee's wages up to the taxable maximum, even though only one of the employers actually paid the employee's total wages.

The effect of the committee decision is that related corporations would pay no more employer taxes than if the corporations were only one employer even though the worker is actually employed by the several corporations and his compensation reflects services he performs for the several corporations. Thus, a related group with a common paymaster would be treated as a single corporation and would not be required to pay the taxes that would otherwise be due because the worker is an employee of the several corporations. The provision is intended to have no effect, by inference or otherwise, on the deductibility for Federal income tax purposes of employment taxes or wages payable by a corporation. The committee expects the Secretary of the Treasury to specify the degree of relationship required to enable corporations to establish a common paymaster for purposes of this provision.

The committee notes that since other provisions of the bill would raise the employer taxable earnings base for social security purposes to $50,000 beginning in 1979 and to $75,000 in 1985, the combined effect of that provision and the provision limiting employer tax liability of certain related corporations—insofar as employer social security tax liability is concerned—would be limited to a relatively small number of workers with high annual earnings.

Cost.—The revenue loss associated with this provision is estimated to be less than $25 million in social security taxes and in unemployment taxes.

RETROACTIVE PAYMENT OF REDUCED BENEFITS

(Section 125 of the Bill)

The present law provides that benefits can be paid for as many as 12 months before the date an application for benefits is filed. This provision was intended to assure that an individual who, for one reason or another, could or did not make a timely application for benefits would not lose any of the benefits to which he would have been entitled. At the same time it was recognized that the purpose of the program—to provide income to help meet current living costs—would not be achieved if an individual were permitted to forego monthly benefits in order to accumulate a large lump-sum payment. The 12-month limit on the payment of retroactive benefits is a compromise between the two conflicting objectives of providing income to help meet current expenses and preventing the loss of benefits merely because of difficulties in filing a benefit application at a specific time.

The committee was informed that the present retroactive payment provisions permit the payment of a windfall benefit in certain cases where an individual learns at the time he files for benefits that he could be paid retroactive benefits provided that he accepts a reduced payment for the rest of his life. The committee views such a situation as a distortion of the primary purpose of the program which is to provide a continuing source of income after earnings under social security are lost (e.g., through retirement in old age). It is not the purpose of the program to provide large lump-sum payments, particularly where providing such one-time payments results in a lessening of the adequacy of the on-going monthly benefit level.

Under the committee bill, monthly benefits generally would not be paid retroactively for months before the month in which the application was filed if it would cause reduced benefits to be paid. An exception, however, would be made if unreduced dependent's benefits are payable in addition to the reduced benefit.

Under present law, the applicant-beneficiary who is eligible for reduced benefits may be faced with options that are unclear and misleading to him, and which could make it difficult for him to decide whether or not to elect reduced benefits. For example, if a worker's monthly benefit amount were $160 as of the month he attained age 65 and filed an application, he could get a lump-sum payment of $1.792.80 if he elected to have his monthly benefits reduced by $10.60 to $149.40.

The committee has been concerned about the high proportion of applicants in such situations who choose to receive a relatively high onetime retroactive benefit payment, even though it means a permanent reduction in the monthly benefits they would get in the future. It is this continuing income on which they have to rely for the remainder of their lives; it may be too small to adequately provide for current needs. Under the proposed change. many older beneficiaries would have higher incomes to meet their ongoing needs.

Costs and number of people affected.—About 1 million people would be affected by the provision in the first year. This provision would reduce the long-term cost of the program by 0.01 percent of taxable payroll and would cause a reduction in payments for the first few years it is in effect ranging from $0.4 billion in calendar 1978 to $0.6 billion in 1982.

Effective date.—The provision would become effective with respect to benefits payable for months after the month of enactment on the basis of applications filed after the date of enactment.

DELIVERY OF SOCIAL SECURITY AND SSI CHECKS

(Section 126 of the Bill)

Under present law, social security benefit payments for a particular month are payable after the end of that month. and payment is normally made on the third day of the month; SSI benefit checks for a particular month are delivered on the first day of that month.

The committee has been concerned that social security and SSI beneficiaries have to wait several days before they could get their benefit checks cashed in those instances where the usual delivery date fell on a Saturday, Sunday, or legal holiday.

The committee bill would require that, when the delivery date for either payment falls on a Saturday, Sunday, or legal holiday, the checks would be delivered on an earlier date.

BENEFIT INCREASES AS APPLIED TO REDUCED BENEFITS

(Section 127 of the Bill)

Because of the way in which benefit increases are computed, people who initially received actuarially reduced benefits sometimes receive an increase which is a greater percent of their total benefit than the increase provided generally. For example, when a cost-of-living increase is provided, these people receive an increase which is larger than the increase in the cost of living. This occurs because the percentage increase is applied not to the actual benefit amount but to the basic benefit rate (the primary insurance amount) which equals the amount that would be paid to a retired worker who began drawing benefits at age 65. If an individual begins getting benefits prior to age 65 and therefore accepts an actuarially reduced benefit rate, subsequent benefit increases are larger than is necessary to keep that benefit up to date with increases in the CPI.

The fact that subsequent benefit increases are not actuarially reduced to the same extent as the original benefit complicates the processing of benefit increases, makes the program less easily understandable, and violates the actuarial neutrality of the decision as to whether or not to take benefits prior to age 65. The last factor would become particularly significant under the provision in the bill which raises the retirement test exempt amount to $6,000. Under that change, some social security benefits will be payable to persons earning in excess of $10,000 per year. A person under age 65 will in many cases be able to begin getting benefits while still employed. The incentive for such an individual to claim reduced benefits will be substantially greater if subsequent benefit increases are exempt from the reduction factor applied to the original benefit.

In view of all these factors, the committee bill modifies the provisions relating to benefit increases so that the across-the-board percentage increase will apply to the benefit actually being paid rather than to the "primary insurance amount." Under this provision, all beneficiaries on the rolls at the time of an increase will get the same percentage increase in their benefits.

Costs and number of people affected.—About 14 million people who receive actuarially reduced benefits for June 1978, when the next cost-of-living increase is effective would be affected by the provision. In calendar year 1979 (the first year in which it has a full-year effect), the provision will reduce benefit payments by $230 million.

Effective date.—The provision would become effective with respect to benefit increases which go into effect after December 1977.

TOTALIZATION AGREEMENTS

(Section 128 of the Bill)

There is at present no authority in the Social Security Act authorizing the President to enter into agreements (totalization agreements) with other countries to provide for coordination between social security systems. Lack of coordination with the systems of other countries has two disadvantages.

First, the work of U.S. citizens employed by U.S. employers in foreign countries is subject to the social security taxes of the United States and is also subject to the social security taxes of the foreign country. The tax payments to foreign systems may be higher than in the United States and American workers generally get little or no return for the taxes they and their employers pay to the foreign systems because social security eligibility requirements are usually stricter under foreign systems.

Second, U.S. citizens who divide their working careers between work covered under the U.S. social security system and work covered under a foreign social security system suffer a loss of continuity in their social security coverage. Some who work abroad for a number of years and have periods of coverage under two or more social security systems may not qualify for benefits under one or more countries when they retire, become disabled, or die. (For example, American workers who work abroad for a number of years may lose their U.S. social security disability protection because to be insured for disability benefits they must generally have substantial recent work covered by the U.S. system.) Others may qualify for social security benefits but the social security benefits they receive may be small because not all their employment can be taken into account.

The committee bill would help solve these problems by authorizing the President to enter into bilateral agreements with foreign countries to provide for limited coordination between the U.S. social security system and those of other countries. Each agreement would be submitted to the Congress along with a report of the number of people who might be affected by the agreement and the effect the agreement would have on the long-term and short-term income and outgo of the social security system. Each House would then have 90 days (counting only days in which it was in session) to consider the agreement. Should either House pass a resolution within that period disapproving the agreement, the agreement would not go into effect.

Each agreement should provide for the elimination of dual social security taxation and coverage for the same work. An agreement could also provide that each country would take into account a worker's total work and earnings in both countries for purposes of determining eligibility for and the amount of benefits. Each country would pay only a part of the totalized benefit; the amount of the benefits paid would be the proportion of the totalized benefit which is attributable to the covered work performed in the paying country. The United States would not pay a totalized benefit to a worker who had less than six quarters of coverage under the U.S. system. Totalization would improve protection for people who work in both countries. In a large proportion of these cases, if the worker is insured based on his U.S. work alone, his regular social security benefits would be higher than his totalized benefit. In such cases, the worker would be able to receive the higher benefit.

Totalization agreements (which are common among European countries) are considered to have an advantage over other approaches to coordination in that the agreements are designed to allow each cooperating country to carry out its responsibilities virtually independently. The countries exchange information on covered earnings and earnings credits and provide other administrative assistance, but otherwise each country makes its determinations and computations independently and pays benefits directly, without any need for an interchange of funds or balancing of amounts paid as benefits.

A number of countries, including Italy, West Germany, Switzerland, Canada, France, and Japan, have approached the United States about the possibility of concluding social security totalization agreements, and the Social Security Administration has had technical discussions with representatives of each of these countries except Japan. A totalization agreement between the United States and Italy was signed in 1973 and a totalization agreement between the United States and West Germany was signed in 1976, to signify that the countries accepted the text of the agreement for purposes of seeking enabling legislation from their national legislatures. Both Italy and Germany have enacted enabling legislation, but the agreements cannot become effective until they are authorized for the United States as provided in the committee amendment.

EMPLOYEES OF CERTAIN NONPROFIT ORGANIZATIONS

(Section 129 of the Bill)

The committee bill contains an amendment designed to correct the effect of the constructive waiver provisions of Public Law 94-563 which caused substantial and unintended liabilities for retroactive social security taxes.

Services performed in the employ of a religious, charitable, or other organization that is exempt from income taxes under section 501(c)(3) of the Internal Revenue Code are excluded from social security coverage, unless the employing organization files a certificate provided for under section 3121(k) of the Code waiving its exemption from social security taxes together with a list of current employees who concur in the filing of such certificate. Thereafter, social security coverage and tax liability attach to those listed employees and all employees subsequently hired by the organization.

It was discovered during the 94th Congress that a substantial number of nonprofit organizations had been paying social security taxes although not formally in compliance with the waiver procedure. Some organizations had in fact demanded and obtained large-scale refunds and caused retroactive elimination of their employees' social security coverage. To foreclose abuse of the program, Congress enacted Public Law 94-563 which provides, in effect, for constructive filing of waiver certificates in certain instances where taxes were paid.

Public Law 94-563 dealt with the organizations differently depending on whether they had withdrawn from improperly established coverage and had obtained a refund (or tax credit) prior to September 9, 1976. Organizations that had obtained a refund were given a 6-month period (which ended April 18, 1977) to file an actual waiver certificate together with a list of employees who wished to have their coverage reinstated. Refunded taxes with respect to those employees only would have to be repaid and they could be repaid through an installment arrangement. Failure to file a waiver certificate within the 6-month period resulted in a deemed filing of such a certificate and liability on the part of the employer for the payment of both employer and employee taxes due for the retroactive period.

Organizations which had not obtained a refund prior to September 9, 1976, were simply deemed by Public Law 94–563 to have filed a valid waiver certificate covering all employees with respect to whom taxes had been paid. No special provisions for the exclusion of their employees or repayment of their retroactive tax liability were included in Public Law 94–563, since it was assumed that such organizations would generally be current in their social security tax payments and that they had simply been unaware that they were exempt from the social security tax requirements.

This legislation has created problems for organizations that paid social security taxes for some period prior to learning of their failure to file a valid waiver certificate. Instead of requesting a refund of incorrectly paid taxes, some of these organizations merely terminated payments. Last year's legislation deems these organizations to have filed a constructive waiver with respect to employees for whom they previously paid social security taxes and requires them to pay social security taxes for the retroactive period from the time they stopped paying them. Moreover, the law does not allow them the option of paying this newly created past liability in installments. There exists as well a substantial liability for social security taxes for all employees hired after the "deemed-filing" date.

Similarly affected by Public Law 94–563 are certain nonprofit organizations that terminated social security payments and sought a refund but did not receive that refund until after September 8, 1976. Those organizations became, by operation of last year's bill, liable for repayment of the refund and for social security taxes on the wages of their employees for the period dating from their termination.

In addition, a large number of affected organizations qualifying for treatment under section 3121(k)(5) did not meet the filing date in the original law, in large part due to misunderstanding and confusion with respect to their obligations and liabilities under the provisions of Public Law 94–563.

The committee bill would provide that nonprofit organizations that ceased paying social security taxes on earnings of their employees before October 1, 1976, without receiving a refund of social security taxes they had paid in the past, would not be liable for any social security taxes from the time that such taxes ceased to be paid through June 30, 1977, and any taxes that had been paid, after the enactment of Public Law 94–563 which would not be required under the committee amendment would be refunded.

Those organizations that received refunds or credits of taxes after September 8, 1976, would, under the provision of the committee bill, be treated the same as those organizations that had ceased paying social security taxes. Thus, such organizations would not be liable for taxes on their employees' services prior to June 30, 1977, for which they received refunds. However, no social security credits would be given to employees for services rendered during the period for which social security taxes would be forgiven by the bill, but a worker for whom taxes were paid in the past may file a claim by April 15, 1980, to have the taxes for the nonpayment period paid and receive social security credit for such period.

The bill would also extend until December 31, 1977, the period during which those organizations that had received a refund or credit of social security taxes could file an actual waiver certificate to cover their employees under social security. Under Public Law 94-653, this period expired on April 18, 1977.

SPECIAL HEW STUDIES

(Section 201 of the Bill)

Because of the high priority with which the committee views the need to restore the social security program to financial soundness, it has largely limited its consideration of the current legislation to improvements in the funding of the program together with a few specific benefit changes. The committee recognizes, however, that there remains a need for review of many basic structural aspects of social security such as the problems of the disability program, the question of extending coverage to public employees, and the interrelationship of social security with other public and private income support programs. The committee intends, once the fiscal integrity of the existing system has been assured, to undertake a close examination of some of these structural questions. Some of the areas to be examined by the committee and the Congress in the future will require the availability of certain research data and analyses which are not now available. The committee has identified two areas in particular in which it believes that studies are clearly needed.

Study of spouse's benefits.—The social security benefit structure is designed to provide income replacement not only for the insured worker but also to provide additional benefits when that worker has a dependent spouse (and/or dependent children). The benefit structure was designed during a period when it was considered reasonable to assume that a wife would largely be dependent upon her husband's income. Today, a far greater proportion of married women have a substantial involvement in the work force. At the same time, however, it remains true that many women do not have a separate income. In addition, increasing attention is being paid today to the appropriateness of laws which treat, or appear to treat, men and women differently, and some such provisions in the Social Security Act have been successfully challenged on this basis in the courts. The committee believes that it will quite likely find it necessary to consider legislation dealing with these questions in the near future and the consideration of such legislation will be greatly aided if the Department undertakes now a thoughtful analysis of these issues which could be available when the committee considers these issues. For this reason, the committee bill requires the Department to study and report on proposals to eliminate dependency as a factor in the determination of entitlement to spouses' benefits and on proposals related to equal treatment of men and women under the social security program. Elements to be considered in the study include the nature and extent of women's participation in the labor force, the divorce rate, and the economic value of women's work in the home. In conducting this study, the Department would be directed to consult with the Justice Department Task Force on Sex Discrimination.

Study of consumer price index.—In the past few years, the automatic benefit adjustment provisions in the social security law have used the Consumer Price Index as a benchmark for adjusting the benefit formula as it applies both to persons already on the benefit rolls and as it applies to determining the initial benefit amount for new retirees. Under the revised benefit adjustment provisions of the committee bill, the Consumer Price Index will in the future be used solely as a mechanism for keeping benefits inflation proof once an individual is on the rolls. While the Consumer Price Index is the usually accepted measure of the rate of inflation, it is constructed in such a manner as to reflect the impact of rising prices on specific population groups. Some concern has been expressed for several years over the possibility that consumption patterns of elderly persons may differ so greatly from those groups covered by the CPI survey as to make the Consumer Price Index an inappropriate measure of the impact of inflation on the purchasing power of social security benefits. The committee believes that this is an issue which ought to be resolved and has included in the bill a requirement that the Department of Labor, in consultation with HEW, study the need to develop a special consumer price index for the elderly.

PERMANENT STATUS FOR TEMPORARY ADMINISTRATIVE LAW JUDGES

(Section 202 of the Bill)

The committee bill contains a provision which would convert to regular administrative law judges (ALJ's) the temporary ALJ's who were appointed under Public Law 94-202 to hear cases under titles II, XVI, and XVIII of the Social Security Act through 1978. These hearings officers have conducted hearings under the provisions of the Administrative Procedure Act (APA) in the same manner as regular ALJ's.

When Public Law 94–202 was enacted, Congress intended that these hearings officers would be converted expeditiously to regular ALJ status with great weight being given to their extensive adjudication experience in the social security definition of disability. Since then, only a few hearings officers have been appointed to regular ALJ positions.

One of the principal objectives of Public Law 94–202 was to make clear that Congress intended that SSI adjudications were under the Administrative Procedure Act and that SSI hearings examiners could hear all types of social security cases. The process of selecting ALJ's on the basis of this experience envisioned in Public Law 94–202 has not taken place. In making selections, the Civil Service Commission has not given adequate credit for the actual experience the temporary ALJ's obtained in adjudicating social security cases over a substantial period of time. The committee believes that this experience is most valuable and pertinent in appointing regular social security ALJ's.

To correct this situation, the bill would provide that the hearing officers appointed under section 1631(d)(2) of the Social Security Act (as in effect prior to January 2, 1976) to hold hearings under the supplemental security income program who had been deemed to be appointed under and governed by the provisions of the Administrative Procedure Act of Public Law 94–202, shall be appointed to career-absolute ALJ positions as if they had been appointed under the Administrative Procedure Act, section 3105 of title 5, United States Code. They would have the same authority and tenure as hearing examiners appointed directly under section 3105 and be compensated at the same rate as social security ALJ's (GS–15). All provisions of the Administrative Procedure Act shall apply to them in the same manner as they apply to other administrative law judges. The former temporary black lung ALJ's who were appointed as temporary ALJ's under the authority of Public Law 94–202 are fully covered by this provision.

DELAY IN REPORTING DATE FOR SOCIAL SECURITY ADVISORY COUNCIL

(Section 203 of the Bill)

The Social Security Act requires that an advisory council on social security be appointed every 4 years. The statutory reporting date for the advisory council that is to be appointed this year is January 1, 1979. In view of the substantial changes in social security financing included in this bill, the committee believes it would be appropriate to provide a reasonable extension in this deadline so as to enable the coming advisory council more time to take into account the impact of this legislation. For this reason, the committee has included in the bill a 9-month extension—to October 1, 1979—of the reporting date.

C. Public Assistance Amendments

FISCAL RELIEF FOR STATE AND LOCAL WELFARE COSTS

(Section 301 of the Bill)

Present law.—The AFDC statute provides Federal matching of State AFDC cash maintenance payments at a rate of 50 to 83 percent, depending upon the State's per capita income. Overall, on a nationwide basis, the Federal Government provided about 54 percent of the funds for AFDC payments in fiscal year 1976, and the States and localities provided about 46 percent.

Between 1973 and 1977, the cost of the AFDC program to States and localities increased from about $3.4 billion to $5.2 billion, or about a 52-percent increase. In that same period the costs to States and localities of the AFDC, supplemental security income, social services, medicaid and general assistance programs combined grew from $10.3 billion to nearly $17.8 billion, or a 62-percent increase.

These statistics testify to the burden of the major welfare programs on State and local governments, a burden which has reached disturbing proportions, especially in certain areas of the country. The table below shows the distribution of expenditures for AFDC payments for each State:

AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC), TOTAL MAINTENANCE ASSISTANCE PAYMENTS, FISCAL YEAR 1976

State	Total payments computable for Federal funding	Federal funds (unadjusted)	Local funds	State funds	Percentage		
					Federal funds	Local funds	State funds
Alabama	$61,864,423	$46,923,718		$14,940,705	75.8	0	24.2
Alaska	13,457,182	6,623,664		6,833,518	49.2	0	50.8
Arizona	33,977,273	18,895,181		15,082,092	55.6	0	44.4
Arkansas	50,159,256	37,418,805		12,740,451	74.6	0	25.4
California	1,424,692,553	712,346,276	$253,580,487	458,765,790	50.0	17.8	32.2
Colorado	83,227,441	45,517,087	16,700,968	21,009,386	54.7	20.1	25.2
Connecticut	131,786,271	65,893,135		65,893,136	50.0	0	50.0
Delaware	23,649,023	11,824,511		11,824,512	50.0	0	50.0
District of Columbia	91,865,652	45,932,825		45,932,827	50.0	0	50.0
Florida	120,436,323	68,315,478		52,120,845	56.7	0	43.3
Georgia	122,679,985	90,120,035		32,559,950	73.5	0	26.5
Guam [1]	1,511,650	755,825		755,825	50.0	0	50.0
Hawaii	64,632,077	32,316,039		32,316,038	50.0	0	50.0
Idaho	19,796,706	13,497,394		6,299,312	68.2	0	31.8
Illinois	720,065,139	358,715,572		361,349,567	49.8	0	50.2
Indiana	115,583,003	66,425,552	20,351,153	28,806,298	57.5	17.6	24.9
Iowa	98,783,931	56,435,260		42,348,671	57.1	0	42.9
Kansas	67,602,756	36,519,009		31,083,747	54.0	0	46.0
Kentucky	132,730,945	94,730,076		38,000,869	71.4	0	28.6
Louisiana	98,429,037	71,272,467		27,156,570	72.4	0	27.6
Maine	46,662,236	32,943,539		13,718,697	70.6	0	29.4
Maryland	154,441,383	77,220,692	4,413,052	72,807,639	50.0	2.9	47.1
Massachusetts	415,121,135	207,560,568		207,560,567	50.0	0	50.0
Michigan	746,719,100	373,359,550		373,359,550	50.0	0	50.0
Minnesota	156,149,764	88,757,624	29,087,774	38,304,366	56.9	18.6	24.5
Mississippi	32,017,662	26,504,646		5,513,016	82.8	0	17.2
Missouri	140,017,934	85,774,453		54,243,481	61.3	0	38.7

Montana	12,786,884	8,082,589	1,008,552	3,695,743	63.2	7.9	28.9
Nebraska	28,780,341	15,998,096		12,782,245	55.6	0	44.4
Nevada	10,317,578	5,158,789		5,158,789	50.0	0	50.0
New Hampshire	23,673,490	14,270,380	6,700	9,396,410	60.2		39.7
New Jersey	426,793,857	213,396,928	52,226,857	161,170,072	50.0	12.2	37.8
New Mexico	32,125,612	23,544,860		8,580,752	73.3	0	26.7
New York	1,563,184,768	766,768,978	428,746,351	367,669,439	49.1	27.4	23.5
North Carolina	123,889,145	84,281,786	19,711,194	19,896,165	68.0	16.0	16.0
North Dakota	13,122,019	7,556,970	1,044,992	4,520,057	57.6	8.0	34.4
Ohio	446,319,654	242,753,261		203,566,393	54.4	0	45.6
Oklahoma	65,506,367	44,164,394		21,341,973	67.4	0	32.6
Oregon	113,521,471	67,023,078	1,165	46,497,228	59.0		41.0
Pennsylvania	650,945,260	360,558,579		290,386,681	55.4	0	44.6
Puerto Rico	24,171,922	12,085,960		12,085,962	50.0	0	50.0
Rhode Island	51,270,478	28,993,455		22,277,023	56.5	0	43.5
South Carolina	46,352,487	35,670,249		10,682,238	77.0	0	23.0
South Dakota	20,140,672	13,540,573		6,600,099	67.2	0	32.8
Tennessee	85,756,646	62,722,396		23,034,250	73.1	0	26.9
Texas	137,686,030	100,157,072		37,528,958	72.7	0	27.3
Utah	35,237,274	24,680,187		10,557,087	70.0	0	30.0
Vermont	26,538,100	18,528,902		8,009,198	70.0	0	30.0
Virgin Islands	1,849,649	924,824		924,825	50.0	0	50.0
Virginia	138,678,345	80,904,947	1,462,344	56,311,054	58.3	1.1	40.6
Washington	160,546,774	86,245,728		74,301,046	53.7	0	46.3
West Virginia	52,466,290	37,671,723		14,794,567	71.8	0	28.2
Wisconsin	210,875,774	126,335,680		84,540,094	59.9	0	40.1
Wyoming	4,900,181	2,986,169	684,505	1,229,507	60.9	14.0	25.1
Total	9,675,496,908	5,257,605,534	829,026,094	3,588,865,280	54.3	8.6	37.1

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[1] The sum of $755,825 was reported by Guam as a *local* expenditure; but is reported here as a *State* (territorial) expenditure. Adjustments have been made for errors in the printed report.

Source: Office of Financial Management. Division of Finance. Fiscal year 1976 State expenditures for public assistance programs approved under titles I, IV–A, X, IV, XVI, XIX, XX of the Social Security Act. (SRS) 77–04023. This report is compiled from State expenditure reports submitted quarterly by States.

Committee provision.—The committee bill includes several provisions which, over the long term, should assist the States in bringing their welfare costs under greater control. The committee is convinced, however, that in the meantime State and local governments should be given some immediate relief from their fiscal burden.

The committee amendment would provide the States with $400 million in fiscal relief in fiscal year 1978.

Since one of the major elements of State and local welfare costs is the AFDC program, the committee bill provides that half of the fiscal relief payment would be allocated among the States in the same proportion as AFDC expenditures for December 1976. However, State and local welfare costs also arise from a variety of other programs which provide assistance and services to the needy. The distribution of costs under these other programs does not necessarily follow the same pattern as AFDC. The committee believes it can most appropriately recognize other elements of the welfare burden on States and localities by utilizing the general revenue sharing formula for allocating the other half of the payment. The committee recognizes that States and local governments have been led to expect that the Federal Government would provide them with some fiscal relief from their welfare costs. The committee believes that the amount provided in this bill represents a significant step in this direction, taking into account the needs of the States and localities as well as the fiscal situation of the Federal Government.

Although in most States the cost of the non-Federal share of AFDC is borne entirely by the State, a number of States require substantial contribution by localities to the cost of the program. States reporting local contributions ranging from 1 to 27 percent of the cost of AFDC maintenance payments in fiscal year 1976 include: California, Colorado, Indiana, Maryland, Minnesota, Montana, New Jersey, New York, North Carolina, North Dakota, Virginia, and Wyoming. Localities in these States can expect to benefit from the provision in the committee bill which requires the States to pass the fiscal relief through to localities in any case where local governments pay part of the program's costs. However, States would not be required to pass through an amount in excess of 90 percent of the AFDC costs for which the local government was otherwise responsible.

Although the fiscal relief provisions of the committee bill would be computed under a formula related in part to the AFDC program and would be provided to the States in the form of increased funding for that program, the committee wishes to make clear that it views these provisions as an attempt to provide some relief for the overall welfare burden faced by the States. That burden falls not only on the AFDC program but also in the areas of aid to the aged, blind, and disabled in States which supplement the SSI program, in general assistance, and in programs of social and child welfare services.

The table below shows how the fiscal relief payment under the bill would be distributed among the States:

FISCAL RELIEF FOR STATES UNDER COMMITTEE BILL

[Dollars in thousands]

State	Percentage distribution	State fiscal relief payment November 1977
Alabama	1.2	$4,663
Alaska	.2	791
Arizona	.7	2,795
Arkansas	.7	2,930
California	13.5	54,001
Colorado	1.0	3,787
Connecticut	1.3	5,282
Delaware	.3	1,118
District of Columbia	.6	2,578
Florida	2.1	8,452
Georgia	1.6	6,284
Guam	(*)	101
Hawaii	.6	2,434
Idaho	.3	1,094
Illinois	6.2	24,854
Indiana	1.6	6,495
Iowa	.1	4,167
Kansas	.8	3,204
Kentucky	1.5	6,086
Louisiana	1.6	6,409
Maine	.5	2,099
Maryland	1.8	6,994
Massachusetts	3.8	15,341
Michigan	5.6	22,506
Minnesota	1.7	6,890
Mississippi	.9	3,499
Missouri	1.7	6,695
Montana	.2	955
Nebraska	.4	1,758
Nevada	.2	665
New Hampshire	.3	1,046
New Jersey	3.7	14,868
New Mexico	.5	1,971
New York	14.2	56,600
North Carolina	1.9	7,493

See footnotes at end of table.

FISCAL RELIEF FOR STATES UNDER COMMITTEE BILL—Con.

[Dollars in thousands]

State	Percentage distribution	State fiscal relief payment November 1977
North Dakota	.2	704
Ohio	4.2	16,689
Oklahoma	.9	3,694
Oregon	1.2	4,746
Pennsylvania	6.0	24,044
Puerto Rico	.2	962
Rhode Island	.5	1,936
South Carolina	.9	3,564
South Dakota	.2	976
Tennessee	1.3	5,294
Texas	3.1	12,438
Utah	.5	1,848
Vermont	.3	1,033
Virgin Islands	(*)	70
Virginia	1.7	6,789
Washington	1.5	5,834
West Virginia	.7	2,856
Wisconsin	2.3	9,169
Wyoming	.1	466
Total	100.0	400,000

*Less than .05 percent.

QUALITY CONTROL INCENTIVES TO REDUCE ERRORS

(Section 302 of the Bill)

Background.—For at least the last 25 years there has been recognition at the Federal level of the need for a program to reduce errors in the Federal-State public assistance programs. "Quality control" techniques were first used on a limited basis in 1952. However, at that time they were limited to periodic Federal reviews of samples of case records. No verification was made of the information in the case file, and full field investigations were not part of the system. As the result of a nationwide study in the early 1960's that indicated widespread ineligibility in some States, the Department of Health, Education, and Welfare developed a new and expanded quality control system to be implemented by January 1964 in all States for all public assistance programs. This new system also produced little in the way of results, and the quality control program underwent major revision again in 1970. Basic changes made at that time included the use of field investigations, requirements on States for reporting of results, the establishment of acceptable error levels, and implementation of corrective actions.

Both the States and the Department of Health, Education, and Welfare showed a lack of initiative in implementing the new system. However, in 1973 HEW issued a new set of quality control regulations for AFDC. They differed from the 1970 rules in one major aspect—they set forth a procedure by which the Department would not match portions of State claims for AFDC payments based on the extent to which the State's error rates exceeded the acceptable Federal tolerance levels. These levels were set at 3 percent for ineligible cases, 5 percent for overpaid cases, and 5 percent for underpaid cases.

The error measurement and corrective action components of the quality control program have not been questioned. As we stated in the May 1976 Federal district court decision (*Maryland* v. *Mathews*), "plaintiffs assert that they do not question HEW's right to set quality controls." However, the legality of the "disallowance" or "fiscal sanction" provision for limiting Federal matching with respect to State claims has been challenged. In the above cited case the judge ruled that "under the Secretary's rulemaking power to assure the efficient administration of the [Social Security Act], it can be concluded that a regulation establishing a withholding of Federal financial participation in a specified amount set by a tolerance level is consistent with the Act." However, the remainder of the decision invalidated the disallowance regulations based on the unreasonableness of the "tolerance levels" used in determining the extent of any disallowance. As a result of the court decision, fiscal sanctions have never been applied and are no longer a part of the Federal quality control regulations.

Despite the controversy that has existed in the last few years over the penalty aspects of the quality control program, the committee believes that the program has been responsible for significant reductions in State AFDC error rates since 1973. The national average has fallen from a 42.6-percent case erro rrate and a 16.5-percent payment error rate for the period April–September 1973 to a case error rate of 23.2 pecent and a payment error rate of 8.5 percent for July–December 1976. Table shows the changes in payment error rates for each State.

AFDC—CHANGE IN PAYMENT ERROR RATES, JULY TO DECEMBER 1976 OVER APRIL TO SEPTEMBER 1973 [1]

	Amount of payment errors as a percent of total payments											
	Ineligible and eligible overpaid			Ineligible			Eligible but overpaid			Eligible but underpaid		
State	April to September 1973	July to December 1976	Percent change	April to September 1973	July to December 1976	Percent change	April to September 1973	July to December 1976	Percent change	April to September 1973	July to December 1976	Percent change
U.S. average [2]	16.5	8.5	−48.5	9.1	4.6	−49.5	7.4	3.9	−47.3	1.5	.9	−40.0
Alabama	15.1	6.0	−60.3	9.6	2.9	−69.8	5.5	3.1	−43.6	6.5	1.4	−78.5
Alaska	23.1	12.5	−45.9	15.9	9.3	−41.5	6.4	3.2	−50.0	.9	.8	−11.1
Arizona	15.3	12.4	−19.0	7.5	8.2	+9.3	7.7	4.2	−45.5	1.5	1.2	−20.0
Arkansas	3.6	7.3	+102.8	1.8	3.2	+77.8	1.8	4.1	+127.8	1.9	2.2	+15.8
California	12.3	4.7	−61.8	6.9	2.2	−68.1	5.4	2.5	−53.7	1.4	.8	−42.9
Colorado	7.3	7.5	+2.7	2.3	4.1	+78.3	5.1	3.3	−35.3	1.3	.4	−69.2
Connecticut	10.8	7.6	−29.6	5.6	4.4	−21.4	5.2	3.2	−38.5	1.1	.6	−45.5
Delaware	19.6	9.5	−51.5	9.9	6.5	−34.3	9.7	3.0	−69.1	1.5	2.8	+86.7
District of Columbia	18.0	19.8	+10.0	9.8	12.7	+29.6	8.2	7.1	−13.4	.4	1.1	+175.0
Florida	18.8	7.0	−62.8	7.9	3.8	−51.9	10.9	3.2	−70.6	2.5	.7	−72.0
Georgia	14.9	12.2	−18.1	5.1	7.6	+49.0	9.8	4.6	−53.1	2.8	1.1	−60.7
Hawaii	11.2	9.4	−16.1	4.6	5.9	+28.3	6.7	3.5	−47.8	1.3	.6	−53.8
Idaho	9.9	3.8	−61.6	6.3	.4	−93.7	3.6	3.4	−5.6	.3	.9	+200.0
Illinois	22.4	12.1	−46.0	10.9	5.2	−52.3	11.5	6.9	−40.0	1.3	.7	−46.2
Indiana	13.2	2.3	−82.6	7.1	.7	−90.1	6.0	1.6	−73.3	1.0	.2	−80.0
Iowa	15.7	11.0	−29.9	8.3	6.2	−25.3	7.3	4.7	−35.6	1.7	.6	−64.7
Kansas	15.3	5.6	−63.4	8.5	2.6	−69.4	6.7	3.0	−55.2	1.7	.6	−64.7
Kentucky	18.3	6.2	−66.1	7.9	3.2	−59.5	10.4	3.0	−71.2	1.1	.5	−54.5
Louisiana	21.2	8.5	−59.9	13.6	5.0	−63.2	7.6	3.6	−52.6	1.1	.5	−54.5
Maine	7.1	11.6	+63.4	4.1	5.8	+41.5	3.0	5.8	+93.3	.5	.7	+40.0
Maryland	23.0	11.5	−50.0	13.1	6.6	−49.6	9.9	4.8	−51.5	2.0	1.2	−40.0
Massachusetts	15.9	12.0	−24.5	8.5	7.6	−10.6	7.4	4.4	−40.5	.9	.6	−33.3
Michigan	11.4	9.2	−19.3	5.9	4.3	−27.1	5.4	4.8	−11.1	.7	.8	+14.3

Minnesota	9.4	5.8	−38.3	5.0	3.4	−32.0	4.4	2.4	−45.5	1.4	.3	−78.6
Mississippi	5.2	9.2	+76.9	2.0	4.6	+130.0	3.2	4.6	+43.7	1.9	2.2	+15.8
Missouri	12.3	10.5	−14.6	6.8	7.1	+4.4	5.5	3.4	−38.2	1.4	1.2	−14.3
Montana	16.9	13.3	−21.3	7.8	3.9	−50.0	9.0	9.4	+4.4	1.4	2.2	+57.1
Nebraska	8.6	6.9	−19.8	5.4	3.4	−37.0	3.2	3.5	+9.4	(3)	1.4	(4)
Nevada	3.5	.5	−85.7	1.5	....	−100.0	2.0	.5	−75.0	.9	.1	−88.9
New Hampshire	21.4	8.5	−60.3	10.0	4.0	−60.0	11.4	4.6	−59.6	1.3	.6	−53.8
New Jersey	9.4	5.4	−42.6	4.0	2.0	−50.0	5.4	3.4	−37.0	.9	.7	−22.2
New Mexico	6.5	5.4	−16.9	2.5	3.4	+36.0	4.0	2.0	−50.0	1.2	.7	−41.7
New York	26.5	12.1	−54.3	16.4	7.2	−56.1	10.1	4.9	−51.5	1.6	1.1	−31.3
North Carolina	13.2	6.7	−49.2	6.6	2.6	−60.6	6.5	4.0	−38.5	3.9	1.5	−61.5
North Dakota	2.1	3.4	+61.9	....	1.7	(4)	2.1	1.7	−19.0	.7	.2	−71.4
Ohio	21.7	11.3	−47.9	11.5	7.3	−36.5	10.2	4.0	−60.8	1.0	.5	−50.0
Oklahoma	8.1	3.1	−61.7	3.0	1.0	−66.7	5.1	2.1	−58.8	.6	.4	−33.3
Oregon	10.5	7.9	−24.8	6.0	3.6	−40.0	4.5	4.3	−4.4	.7	.6	−14.3
Pennsylvania	24.6	9.3	−62.2	16.4	5.4	−67.1	8.2	3.9	−52.4	1.0	.5	−50.0
Puerto Rico	22.9	8.9	−61.1	14.6	3.8	−74.0	8.4	5.1	−39.3	2.7	2.0	−25.9
Rhode Island	10.7	3.8	−64.5	4.1	1.6	−61.0	6.6	2.3	−65.2	.4	.5	+25.0
South Carolina	17.3	8.5	−50.9	8.7	3.3	−62.1	8.6	5.2	−39.5	2.5	1.7	−32.0
South Dakota	7.7	5.3	−31.2	2.3	2.1	−8.7	5.4	3.2	−40.7	.3	.9	+200.0
Tennessee	12.9	8.6	−33.3	8.2	4.9	−40.2	4.7	3.7	−21.3	1.9	1.1	−42.1
Texas	15.2	5.4	−64.5	8.7	3.4	−60.9	6.5	2.1	−67.7	1.1	.4	−63.6
Utah	9.4	8.1	−13.8	6.0	5.1	−15.0	3.4	3.0	−11.8	.9	.6	−33.3
Vermont	17.9	6.7	−62.6	10.0	1.4	−86.0	7.8	5.3	−32.1	.7	.2	−71.4
Virgin Islands	9.4	16.4	+74.5	4.2	11.4	+171.4	5.2	5.0	−3.8	1.7	2.9	+70.6
Virginia	14.9	6.4	−57.0	5.3	3.6	−32.1	9.6	2.8	−70.8	2.7	1.4	−48.1
Washington	8.0	5.4	−32.5	5.2	2.6	−50.0	2.8	2.8	....	.4	.5	+25.0
West Virginia	10.2	4.9	−52.0	6.4	1.9	−70.3	3.8	3.0	−21.1	.9	.3	−66.7
Wisconsin	7.3	3.9	−46.6	4.2	2.1	−50.0	3.1	1.8	−41.9	1.5	1.1	−26.7
Wyoming	11.3	4.0	−64.6	7.4	1.8	−75.7	3.9	2.2	−43.6	1.9	1.0	−47.4

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[1] See footnote 1, table 11.

[2] See footnote 2, table 11.

[3] Less than 0.05 percent.

[4] See footnote 3, table 11.

Source: U.S. Department of Health, Education, and Welfare.

The committee believes that this progress can be continued, and that with proper incentives the States can be encouraged to decrease the number of errors in their AFDC caseload to more acceptable levels. The committee notes that the General Accounting Office in its recent report on the AFDC quality control program recommended that legislation establishing an incentive for controlling payment errors be enacted.

Committee provision.—The committee amendment would establish a system of fiscal incentives for States to improve their dollar error rates with respect to eligibility and overpayment of aid paid under the approved State plan. Instead of applying sanctions on the States, the dollar error rates would be used as the basis for a system of incentives, which would give the States motivation for expanding their quality control efforts and improving program administration. Under the amendment States which have dollar error rates of, or reduce their dollar error rates to, less than 4 percent but not more than 3.5 percent of the total expenditures would receive 10 percent of the Federal share of the money saved, as compared with the Federal costs at a 4-percent payment error rate. This percentage would increase proportionately as shown in the following table:

If the error rate is:	The State would retain this percent of the Federal savings
At least 3.5 percent but less than 4 percent	10
At least 3 percent but less than 3.5 percent	20
At least 2.5 percent but less than 3 percent	30
At least 2 percent but less than 2.5 percent	40
Less than 2 percent	50

ACCESS TO WAGE INFORMATION FOR AFDC VERIFICATION

(Section 303 of the Bill)

Present law.—Quality control findings indicate that 76 percent of client errors in the AFDC program are the result of non-reporting of income. States have particular difficulty in many cases in verifying the source and amount of earned income. In many cases they are dependent solely on the recipient to supply wage information.

Committee provision.—The committee bill would improve the capacity of States to acquire accurate wage data by providing authority for the States to have access to earnings information in records maintained by the Social Security Administration and State employment security agencies. Such information would be obtained by a search of wage records conducted by the Social Security Administration or the employment security agency to identify the fact and amount of earnings and the identity of the employer in the case of individuals who were receiving AFDC at the time of the earnings. The Secretary of Health, Education, and Welfare would be authorized to establish necessary safeguards against improper disclosure of the information. Beginning October 1979, the States would be required to request and use the earnings information made available to them under the committee amendment.

Although the records of wages maintained by the Social Security Administration and by State employment security agencies may not be available on a current basis, it seems inevitable that a procedure for screening against one or the other of these two sets of records should greatly increase the incentive for recipients to accurately report their earned income. Where welfare agencies are requesting the wage data from the Social Security Administration, each State or local administering agency would designate a single official who would be authorized to make the necessary request for information. Alternatively, procedures for requesting such information could be worked out by mutual agreement of the welfare agency and the Social Security Administration. The cost of searching wage records would be reimbursed to the agency maintaining the records and would be matchable as an administrative expense of the welfare agency.

AUTHORITY FOR STATES TO OPERATE DEMONSTRATION PROJECTS MAKING EMPLOYMENT MORE ATTRACTIVE FOR WELFARE RECIPIENTS

(Section 304 of the Bill)

Present law.—Section 1115 of the Social Security Act allows the Secretary of Health, Education, and Welfare to waive any of the State plan requirements of the Federal welfare law for the sake of experimental, pilot, or demonstration projects which in the Secretary's judgment are likely to assist in promoting the objectives of the welfare programs. The committee notes that under this existing law, there is considerable authority at the Federal level to carry on research and demonstration on better ways of developing work incentives for welfare recipients. Exclusive use of this approach, however, ignores one of the basic strengths of federalism; namely, that individual States should be free to experiment with better ways of solving governmental problems. A number of States have attempted to institute innovative employment programs for welfare recipients but they have been inhibited by HEW because of its slowness to act under current demonstration authority. The committee bill will alleviate this situation.

Committee provision.—Under the committee amendment, which is similar in intent to an amendment reported by the committee and approved by the Senate in 1973 (section 164 of H.R. 3153, 93d Congress), this authority would be both broadened and made more explicit to emphasize a major objective for demonstration projects. This objective is to permit States to achieve more efficient and effective use of funds for public assistance recipients, to reduce dependency, and to improve the living conditions and increase the incomes of persons who are on assistance (or who would be on assistance if they were not participating in the demonstration project) by conducting experiments designed to make employment more attractive for welfare recipients.

States would be limited to not more than three demonstration projects under this authority; one of the projects could be statewide. None of the projects could last for more than 2 years, and all authority for the projects would terminate September 30, 1980.

In pursuing these objectives under the committee bill, States would be permitted for demonstration purposes to waive the requirements of the Aid to Families with Dependent Children program relating to (1) statewideness; (2) administration by a single State agency; (3) the earned income disregard (but in no case could a State offer an earned income disregard of more than 50 percent); and (4) the work incentive program. The State could waive any or all of these requirements on its own initiative. Unless the Secretary, within 45 days, disapproved the waiver as inconsistent with the purposes of section 1115 and the AFDC law, the demonstration would be considered approved and could be operated by the State.

As part of a demonstration project, the State could use welfare funds to pay part of the cost of public service employment. The State could add additional amounts to pay a wage higher than the amount of the welfare payment. Under the committee bill, revenue sharing funds could be used for the non-welfare share of the salaries. The committee amendment requires the States, in making arrangements for public service employment, to provide that appropriate standards for the health, safety, and other conditions applicable to the performance of work and training are established and maintained, that projects will not result in the displacement of employed workers, and that the conditions of work, training, education, and employment are reasonable in the light of such factors as the type of work, geographical region, and proficiency of the participant, and that appropriate workmen's compensation protection is provided to all participants. The State welfare agency would also be free to contract with non-profit private institutions organized for a public purpose, such as hospitals, to carry out such projects.

When unemployed fathers are placed in public service employment, Federal matching will continue for the portion of the salary equal to the former welfare payments and it will be available for wage payments.

Public Service employment is not the only type of experimentation authorized by the committee bill. States may wish, for example, to experiment with the income disregard. If they do so, however, they will not be allowed to conduct a test which disregards more than one-half of a welfare recipient's earned income.

Participation by welfare recipients in the demonstration projects would be voluntary.

The costs incurred by the States in conducting demonstration projects under this provision of the committee bill would be eligible for the same Federal matching as applies to other costs of the AFDC program, subject to the limitation that the amount matchable with respect to any participant in the project may not exceed the amount which would otherwise have been payable to him under the regular provisions of the AFDC program. Thus, these projects should not result in increased Federal expenditures.

EARNED INCOME DISREGARD

(Section 305 of the Bill)

Present law.—Under present law States are required, in determining need for Aid to Families with Dependent Children, to disregard:

1. All earned income of a child who is a full-time student, or a part-time student who is not a full-time employee; and

2. The first $30 earned monthly by an adult plus one-third of additional earnings. Costs related to work (such as transportation costs,

uniforms, union dues, child care and other items) are also deducted from earnings in calculating the amount of welfare benefit.

Three problems have been raised concerning the earned income disregard under present law. First, Federal law neither defines nor limits what may be considered a work-related expense, and this has led to great variation among States and to some cases of abuse. Second, the requirement for itemization of individual work expenses results in administrative complexity and error. Third, some States have complained that the lack of an upper limit on the earned income disregard has the effect of keeping people on welfare even after they are working full-time at wages well above the poverty line.

In an effort to curb the abuse of the work expense provision and to simplify its administration, a number of States in the past established standard amounts to be used in the case of all AFDC recipients with earnings. However, in 1974 the U.S. Supreme Court in *Shea* v. *Vialpando* ruled the policy of using a fixed work expense disregard, regardless of actual costs, as contrary to the Social Security Act. It said, however, that a standard allowance which would enhance administrative efficiency would be permissible if it provided for individualized consideration of expense in excess of the standard amount. Since the ruling, a number of States have used standard amounts for work expenses, but at the same time they are required to allow individual recipients to make additional claims for work expenses if they can show that they do in fact have such expenses.

In the summer of 1975 the Congressional Research Service conducted a survey to determine State practices with respect to work expenses. The responses indicated very wide variations among the States, and also indicated that in most instances individual itemization of work expenses is necessary. An analysis of AFDC work expenses which are allowable in the 42 States responding to the survey showed the following:

Child care.—Twenty-one of the responding States indicated that they imposed no dollar limit on child care expenses. Of those that did, the range of allowable expense was from $17 to $50 a week. (Some States indicated that child care was not an allowable expense under AFDC. Presumably, in those States, if child care were necessary for an AFDC family, it would be provided through title XX vendor payments.)

Transportation, special clothing and lunch.—Ten States indicated that they had a standard amount for two or all of these items, ranging from about $25 to $44 a month. Seven States indicated that they disallowed one or more of the items. More specifically, States reported for:

1. *Transportation.*—Twenty States said they had no limit for transportation expenses. Those that gave mileage limitations ranged from 6 cents to 20 cents a mile. States did not indicate whether they allowed car payments or repairs as work expenses.

2. *Special clothing.*—Twenty-five States indicated that there was no limit for these expenses. The few that have established limits for this category generally specified a limit of $5 a month.

3. *Lunch.*—Fourteen States said they had not established a limit. Those that have, gave a range of from $0.25 to $1 a day.

States did not provide information to indicate what kinds of exceptions they make to their general rules, although it is known that some exceptions are made. For example, New York indicated a limit of $50 a week for child care. However, higher amounts are generally allowable in New York City.

In addition to the above-mentioned items, States generally allow for mandatory tax deductions and union dues.

Committee provision.—The committee believes that the broad discretion that now exists in determining work expenses leads to abuse, and also results in unnecessary administrative complexities and errors. The committee amendment would address these problems by requiring States to disregard the first $60 earned monthly by an individual working full time ($30 in the case of an individual working part-time), in lieu of individual itemized work expenses. In addition, reasonable child care expenses, subject to limitations prescribed by the Secretary, would then be disregarded. To preserve an incentive for additional earnings, but also to provide for a phaseout of welfare payments at a reasonable level, the committee amendment would provide for the disregard of one-third of remaining earnings, up to $300 plus one-fifth of remaining earnings above $500 a month. Thus, in a State where the payment standard is $300 a month for a family of four (in July 1976 the median State's payment standard was $317), the level of earnings at which a family would no longer be eligible for any AFDC payment would be $585 a month (assuming child care expenses of $100). A State which implements this section upon enactment and prior to the effective date would not be regarded as out of compliance with requirements imposed with respect to improved State plans under part A of title IV of the Social Security Act.

The following example compares the effects of present law and the committee bill.

Example: Recipient earns $500 per month, pays $200 for child care; pays $110 for union dues, parking fees, interest on automobile, withholding taxes, etc. State AFDC payment for family with no income would be $300.

	Amount
Present law:	
$500 is reduced by:	
Basic disregard	$30
33⅓ percent of earnings above basic disregard	157
Child care costs	200
Other work expenses	110
Total disregard	497
Family is paid in AFDC:	
$300 full payment less the $3 of earned income which is not disregarded	297
Committee bill:	
$500 is reduced by:	
Basic disregard	60
Allowable child care [1]	150
33⅓ percent of the 1st $300 of earnings above other disregards; 20 percent of earnings above that $300 [2]	97
Total disregard	307
Family is paid in AFDC:	
$300 full payment less the $193 of earned income which is not disregarded	107

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[1] Assumes that HEW limit on deductible child care would be $150 for the individual in this example.

[2] In this example, the excess income above other disregards is only $290; thus the 20-percent factor does not come into play.

in the reduction period beginning with age 62 multiplied by 19/40 of 1 percent, plus the number of months in the adjusted reduction period prior to age 62 multiplied by 19/40 of 1 percent, plus the number of months in the adjusted additional reduction period multiplied by 43/240 of 1 percent to (ii) the number of reduction period prior to age 62 multiplied by 19/40 of 1 percent, plus the number of months in the additional reduction period multiplied by 43/240 of 1 percent, and

(C) in the case of widow's and widower's insurance benefits for the month in which such individual attains age 65, by multiplying such amount by the ratio of (i) the number of months in the adjusted reduction period multiplied by 19/40 of 1 percent, plus the number of months in adjusted additional reduction period multiplied by 43/240 of 1 percent to (ii) the number of months in the reduction period beginning with age 62 multiplied by 19/40 of 1 percent, plus the number of months in the adjusted reduction period prior to age 62 multiplied by 19/40 of 1 percent, plus the number of months in the adjusted additional reduction period multiplied by 43/240 of 1 percent, such decrease being made in accordance with the provisions of paragraph (8).

(11) When an individual is entitled to more than one monthly benefit under this title and one or more of such benefits are reduced under this subsection, the preceding paragraph of this subsection shall apply separately to each such benefit reduced under this subsection before the application of subsection (k) (pertaining to the method by which monthly benefits are offset when an individual is entitled to more than one kind of benefit) and the application of this paragraph shall operate in conjunction with paragraph (8).

* * * * * * *

Increase in Old-Age Insurance Benefit Amounts on Account of Delayed Retirement

(w)(1) If the first month for which an old-age insurance benefit becomes payable to an individual is not earlier than the month in which such individual attains age 65 (or his benefit payable at such age is not reduced under subsection (q)), the amount of the old-age insurance benefit (other than a benefit based on a primary insurance amount determined under section 215(a)(3) *as in effect in December 1978 or section 215(a)(1)(C)(III) as in effect thereafter*) which is payable without regard to this subsection to such individual shall be increased by—

(A) one-twelfth of 1 percent of such amount, multiplied by

(B) the number (if any) of the increment months for such individual.

(2) For purposes of this subsection, the number of increment months or any individual shall be a number equal to the total number of the months—

(A) which have elapsed after the month before the month in which such individual attained age 65 or (if later) December 1970 and prior to the month in which such individual attained age 72, and

(B) with respect to which—

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VII. MINORITY VIEWS OF SENATORS CARL T. CURTIS, CLIFFORD P. HANSEN, ROBERT DOLE, AND PAUL LAXALT

The social security system is in financial trouble because for years the Congress has permitted benefit liberalizations to outpace revenues. Other demographic and economic factors joined to place the system in financial peril, so that virtually all agree that action must be taken to restore its fiscal health.

However, action should not be precipitate or foolhardy. It should not be disruptive of sharing relationships which have existed since the inception of the program. It should not fall heavily and inequitably upon certain sectors of the economy. It should not attempt to mask the real cost of making the system whole.

Most regrettably, the provisions of the bill reported by the Senate Finance Committee—which were approved by a single vote margin in the committee—violate all of these principles. It is a completely unacceptable way to resolve the problems of social security, and its current approach should be rejected by the Senate.

The keystone of the approach in the measure is a unilateral increase in the wage base on which contributions are calculated, for the employer only, to $50,000 in 1979 and to $75,000 in 1985. In a sharp break with precedent and tradition, the bill delivers massive financial blows to the very sector of the economy which is charged with the responsibility of providing sufficient jobs and capital formation in a critical period in our Nation's history.

Specifically, to date, employers and employees have shared equally in the costs of funding social security; present requirements are that each contribute 5.85 percent of the first $16,500 earned by the employee. Under the measure reported by the committee, only modest wage base increases—four $600 increments in 1979, 1981, 1983, and 1985—will be experienced by the employee. The employer, however, will have to pay social security taxes on the first $50,000 of individual covered wages, between 1979 and 1985, and that figure will be increased to $75,000 in 1985.

The sharp impact upon firms, particularly those employing individuals in critically needed higher income specialties, could not be more obvious.

The cost in additional OASDHI taxes, over present law, of the wage base increases contained in the committee bill is as follows:

[In millions]

	Employer	Percent	Employee	Percent
1979	$2,396	93.0	$179	7.0
1980	7,360	92.2	625	7.8
1981	7,855	90.4	835	9.6
1982	8,304	86.8	1,263	13.2
1983	8,503	85.5	1,443	14.5
5-yr average	6,884	88.8	869	11.2

In other words, in 1979, the employer sector will sustain an increase of $2.4 billion in social security contributions because of the wage base increase alone (compared with $179 million by employees). By 1983, increases required by the rise in the base will have grown to $8.5 billion for employers versus $1.4 billion for employees.

The total amount of additional OASDI and HI taxes paid by employers and employees under the committee bill is as follows:

		Employers		Employees	
	Total	Amount	Percent	Amount	Percent
Calendar year:					
1979	$8.3	$7.1	85	$1.2	15
1980	10.0	8.6	86	1.4	14
1981	16.2	11.8	73	4.3	27
1982	17.2	12.4	72	4.8	28
1983	18.3	12.9	70	5.5	30
5-yr average	14.0	10.6	76	3.4	24

Rather than the historic 50 percent-50 percent sharing ratio, the two sectors will stand in a 76 percent-24 percent relationship over the next 5 years. By 1985, when the ceiling on the employer wage base is increased to $75,000, the disparity should become even more pronounced.

In a survey conducted by the Chamber of Commerce of the United States, on a similar plan,[1] over two-thirds of the respondents estimated an increase of over 10 percent in their social security tax. Twenty-seven percent estimated an increase of over 20 percent, and 15 percent said that their taxes would rise by more than 30 percent. Seventy-nine respondents forecasted an increase of over 100 percent in their social security taxes.

Additionally, these increases fall with a significant amount of disparity and inequity, depending upon the type of firm and the wage levels of their particular employees. Another survey, conducted by the minority, of 65 firms, colleges, and universities, found the following projected increased costs:

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[1] A number of the estimates on the economic effect of the provisions of the committee bill are based upon the earlier level of $100,000 for the employer portion of the wage base, except where specifically otherwise stated. As noted in the text, however, the difference in economic effect—because most of the jobs affected are grouped between the currently scheduled $18,900 and $50,000, not above it—is negligible.

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A major private university in the State of New York: $1.3 million.

A leading national rubber company: $6 million.

A major trunk airline, based in the Southeast: $11 million.

A Nebraska-based major construction company: $2.8 million.

A Midwestern State university: $1.4 million.

A textile company in the South: $2 million.

A leading manufacturer of copymaking equipment, headquartered in Connecticut: $27 million.

Two Texas-based national oil companies: $9.1 million and $20 million, respectively.

Two Oregon educational facilities: $2 million and $693,000, respectively.

These are simply representative of the deleterious effect the type of provisions contained in the committee bill will have upon major segments of the American economy.

And it is foolish to believe that American taxpayers will not, ultimately, be paying the resultant cost. They will pay it through increased prices, reduced wages and/or employee benefits, more limited employment opportunities, and delays in planned expansion. Sixty-eight percent of those participating in the chamber survey indicated they would be forced to increase prices to meet the increase in their social security taxes. Over half said they would have to hold down increases in wages and/or employee benefits.

Econometric models run on the earlier Finance Committee plan, raising the employer portion of the wage base to $100,000, revealed that real GNP would be cut by $12.8 billion in 1980 and by $38.5 billion in 1985. Real disposable income would be down, in 1980, by $12.3 billion, and in 1985, by $38.4 billion. The effect on employment was forecast at 400,000 fewer jobs in 1980 and 1,200,000 fewer jobs in 1985. Investment would be down by $5 billion in 1980 and by $16.2 billion in 1985. There is little reason to believe that the economic effects of the committee-approved plan will be any less serious: for increasing the wage base to $50,000 in 1979 and $75,000 in 1985 should cover most, if not all, employee salary levels. In 1979, under the provisions adopted in the committee bill, we estimate that the $5 billion in higher tax collections from wages between the currently scheduled $18,900 and $50,000 will cost $3 billion in reduced business investment, 200,000 fewer jobs, an increase in wage costs of 0.5 percent, and an increase in consumer prices of 0.4 percent. To maintain that the approved levels are any improvement over the original proposal of an employer wage base level of $100,000 is specious.

Surely, the wage base provisions of the committee bill continue to be an inequitable and undesirable solution to the social security problem.

It is equally fallacious to contend, as proponents of the bill do, that the break in this historic equal sharing relationship between employer and employee is only temporary, and that "the wage base for the employee is only temporary, and that "the wage base for the employee will catch up to that of the employer in 2002." Once the break has been made, it will be difficult if not impossible for future Congresses to resist the same illusory expediency that led to the current action, and in the event the bill is adopted in its current form, it is most like that parity never again will be restored.

Employees in the affected industries will not gain a corresponding increase in their benefits, as has been the case in the past when wage bases have been increased. Only modifications in the employee portion of the wage base cause corresponding increases in benefits; those located in industries who are forced to pay the disproportionate share of social security financing under the committee mechanism will derive no benefit at all from the added contribution made in their behalf.

Finally, increasing the taxable wage base narrows, in a most undesirable fashion, the role of private retirement savings efforts. This poses a threat to the long-range future of private pension systems, and therefore is a threat to a major source of equity capital for the future.

Rather than the kind of gimmickry represented in the committee bill, the social security system can and should be financed by straightforward methods which are simple, easy to understand, and are acceptable to both beneficiaries and contributors as necessary and desirable to restore the fiscal solvency of social security. Through either a very small tax rate increase alone (e.g., 0.2 percent in 1979 and 0.3 percent in 1980), followed by rate increases no larger than those already contained in the committee bill for the years from 1985–2011 (and incorporating the other major provisions, such as decoupling), both the short-range and the long-range problems of the trust funds could be completely resolved. Alternatively, the tax rate increase could be slightly smaller in the initial years (e.g., 0.25 percent in 1979, with no increase in 1980), and very slight—and equal—increases in the wage base for both employers and employees could be included (e.g., the four $600 increments that are in the committee bill presently for employees alone), and the result would be virtually the same: fiscal soundness for the trust funds.[2]

It should be possible, after the months and years of detailed consideration of the issue of social security financing, to develop and propose to the American people a solution which is based upon the fundamental principles of:

retaining the historic equal sharing relationship between employer and employee in the funding of the program, and

establishing a method of financing that does not attempt to hide the true costs of social security.

It is most unfortunate that the bill reported from the committee adheres to neither of these essential precepts. Were the alternatives which were available to the committee so onerous, or so difficult to implement, that they were not realistic or viable, we could understand the action which was taken. The fact is, however, that numerous alternatives were presented which would have been realistic and practical and could be implemented without undue hardship. Adoption of any one of these rather than the ill-conceived plan contained in the committee bill—infinitely would better serve the needs of the social security system and the American people.

CARL T. CURTIS.
CLIFFORD P. HANSEN.
ROBERT DOLE.
PAUL LAXALT.

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[2] The level of increased taxes by the average social security wage base earner in 1979 would be only $23 under the first plan and $29 under the second—surely affordable levels.

VIII. ADDITIONAL VIEWS OF SENATORS ROBERT DOLE AND WILLIAM V. ROTH, JR.

There is no question that the social security trust funds, after years of legislative liberalizations without accompanying revenue measures, is in need of corrective action to make it fiscally sound. We question, however, whether those who now must bear the burden of financing social security—the working men and women of America—should be asked to assume such massive burdens that the legislation currently under consideration would impose.

These social security taxpayers recognize the necessity of continuing to make the system sound for the currently retired. They also look with concern to the day when they, too, will begin receipt of Social Security. They also look with mounting concern at the escalating demands government is imposing upon their paychecks, for they must—rightly—be concerned with cash flow in a time of increasing financial difficulty for so many.

We believe:

that the social security system should be operated as carefully, and as soundly, as any private system;

that constantly increasing tax demands, either through the tax rate or the wage base, is not the answer;

that we must look to the beneficiary composition, the benefit structure, and the relationship between Social Security and other public and private programs to assess the most rational way of bringing fiscal sanity to this program; and

that the Congress should not move into hasty enactment of tax or wage base increases until the kind of careful analysis described is completed.

In the minds of many, social security is synonymous with planning safely for retirement. In the minds of others, it is a program that has grown out of control, threatening their very ability to meet its mounting drain upon their take-home pay. For many in the latter group, social security taxes may consume more of their income than direct taxes on that income itself.

We owe it to both of these groups to do a thorough and complete job of reforming the social security system. We do not believe that either the Committee bill, or the House-passed legislation, accomplishes this critical goal. Much more creative thinking needs to go into the range of alternatives which are possible in this important area.

Bob Dole.
William V. Roth, Jr.

IX. ADDITIONAL VIEWS OF SENATOR JOHN C. DANFORTH

I have voted to report H.R. 5322 to the floor despite my serious concerns about the method of social security financing approved by the committee. There is no question that over $70 billion must be raised in the next 5 years if the social security trust funds are to be put on a sound financial basis. For this reason, I have voted to report the bill on the theory that almost any method of raising the revenue is better than no method at all. However, for the reasons set forth in these separate views, I do not believe the program contained in this bill is well conceived.

The financing proposals in this bill coupled with the already scheduled increases will cause social security taxes to rise drastically in the next few years. The State and local governments and nonprofit organizations alone will experience a tax increase of 227 percent in the next 10 years. H.R. 5322 provides some limited fiscal relief for these entities, but, as I set forth below, it is ill-designed relief, arbitrarily excluding many organizations from its scope, and is much too limited.

I. INCREASING THE EMPLOYER'S WAGE BASE TO $50,000 IN 1979 AND $75,000 IN 1985 INTRODUCES ARBITRARY AND CAPRICIOUS DISTINCTIONS AMONG EMPLOYERS AND FAILS TO TAX ON THE BASIS OF ABILITY TO PAY

Heretofore, the social security tax has been imposed one-half on the employer and one-half on the employee up to a specified wage base, currently at $16,500. The tax collected has had a direct relationship to the benefits to which the employee has been entitled.

Under the committee proposal to increase the employer's wage base, the employer will have an additional tax burden which in no way increases the benefits of his employees. The additional tax, then, is not a social security contribution geared to social security benefits, but a general tax.

I oppose pegging this general tax to salary levels without regard to profits, because it produces arbitrary and capricious results. The proposal penalizes the employer who has a generous and liberal wage policy and rewards his competitor who has resisted wage increases. The employer with the liberal wage policy now will have to bear a substantial additional tax burden from which his less generous competitor is exempt. In this regard, it should be noted that we are not talking about salaries of top executives, but salaries above the wage base—$16,500—the salary of plumbers in St. Louis, Mo.

Two manufacturing firms in Louisiana illustrate the problem. Each has over 100 employees. As a result of this provision, the tax liability of one will be increased 98.7 percent; the other only 42 percent. It would be difficult to convince the first employer that his tax increase is not excessive or that he is receiving equal tax treatment.

Further, differing wage structures in various regions in the country and from industry to industry will produce inequitable results under the proposal. Employers who have older, more experienced workers, and employers who are engaged in labor-intensive enterprises will have to bear more than their fair share of the tax burden. Employers in capital-intensive enterprises and those who have younger, less skilled or part-time workers will bear a smaller burden. I know of no public policy which would justify differences in tax treatment on these grounds.

I recognize that the American public will have to bear a substantial financial burden in providing the $70 billion shortfall in social security. However, there is something fundamentally wrong where the method chosen to raise the funds causes tax increases of more than 100 percent on some employers and no or very little tax increase on many others. Thus, a manufacturer in Nebraska reports that he will have a 118-percent increase as a direct result of the proposed base increase. Similarly, a Colorado wholesaler calculates a tax increase of 118 percent. In contrast, a Georgia construction company calculates that its increase will be only 0.006 percent as a result of this proposal.

These widely varying tax increases are wholly unrelated to profits. An employer with a tax increase of over 100 percent may be operating at a loss whereas an employer with little or no tax increase may be enjoying substantial profits. I suggest that where the tax bears no relationship to either the employee's benefits or the employer's profits, then the tax could just as well be imposed on the basis of typewriters, trucks, or inventory.

I also oppose the proposal because of the effect it has on low-income workers and the economy in general. There appears to be an implicit assumption underlying this bill that where the tax is imposed directly on the employer and does not decrease the take-home pay of the worker, the worker wholly escapes the economic burden of the tax. This view is fallacious.

The Joint Economic Committee, in its 1977 Midyear Review of the Economy, dated September 26, 1977, makes clear that a higher employer payroll tax will be shifted backward in the form of lower wages or forward in the form of higher prices, or both. Moreover, as the Joint Economic Committee points out, this shift has a very serious effect on inflation and unemployment. The committee's overall conclusion is that increasing the employer's social security tax by raising the wage base will ultimately reduce the level of both production and employment.

II. RAISING THE TAX AND BASE ON EMPLOYEES IS REGRESSIVE TAXATION AND HAS ITS GREATEST IMPACT ON LOW- AND MIDDLE-INCOME WAGE EARNERS; AND WILL COMPEL STATES, LOCAL GOVERNMENTS, AND NONPROFIT ORGANIZATIONS TO WITHDRAW FROM SOCIAL SECURITY

The social security tax is a regressive tax. According to the administration, at present *more than half of all taxpayers pay more in social* *security tax than in Federal income tax.* In 1976, payroll taxes represented 32 percent of total Federal receipts. Yet, at a time when we are talking about substantially reducing the Federal income tax rates, our most progressive tax, the committee has proposed increasing the present social security tax rate by *20 percent* in the next 8 years as well as increasing the base against which the taxes are assessed.

These rate and base increases emphasize and increase the unfair and regressive aspects of the present social security tax. Although an increase in the base does not increase the taxes paid by those below the base, it substantially increases the tax paid by those slightly above the base, currently at $16,500. For example, the effect of the committee's action with respect to base increases alone on persons earning only $2,400 above the current base will be to increase their taxes by 15 percent by 1985. Therefore, in combination with the rate increases, these persons face social security tax increases of 35 percent.

I also oppose this proposal because of the heavy burden on State and local governments. By 1987—only 10 years from now—this group of employers will suffer social security tax increases of over 200 percent. Most of the increase will result from rate increases. Less than 7 percent of the increase results from lifting the wage base on employers. Thus, most of the increase will be borne without the benefit of the committee's fiscal relief provision. New Haven, Conn., estimates an increase of $40,000 in its social security tax by 1979 alone, an increase of almost 20 percent. The entire amount results from the rate increases. Similarly, Savannah, Ga., will have to pay an additional $48,500 in social security taxes in 1979 over what it is now paying. Only a very small portion of the increase results from the increase in the employer wage base: it is almost entirely a result of the rate increases.

Nonprofit organizations as a group also will have substantial increases under this proposal. This group's liability under social security will also increase over 200 percent by 1987. The Salvation Army in the Greater Washington, D.C., area, covering Virginia, one-half of West Virginia and parts of Maryland, calculates it will have to pay social security taxes of almost $86,000 in 1979 as a result of the committee's proposals, an increase of almost $13,000. All but $15 of that $13,000 increase is a result of the rate increases. Similarly, the Washington, D.C., Campfire Girls calculates it will have an increase of 40 percent in its social security taxes in 1979, all of it attributable to the rate increases. These organizations are not in a position to absorb tax increases of this magnitude.

III. WAGE INDEXING IS MORE EXPENSIVE THAN PRICE INDEXING AND EXCLUDES CURRENT RETIREES FROM SHARING IN AMERICA'S ECONOMIC GROWTH

I support the concept of providing an adjustment in the amount of social security benefits to provide constant dollars to recipients. The committee has proposed achieving this result by indexing social security on the basis of wage increases.

I oppose this method of indexing because it is very expensive and because it draws invidious and unjustified distinctions between retirees of today and retirees 20 years from today. Thus, under wage indexing, a worker who retires today will receive a smaller benefit *in real dollars* than a worker with an identical wage history who retires 20 years from now even though both may be alive and drawing benefits. Under wage indexing, the current retiree is excluded from sharing in the real growth of our Nation's productivity.

I favor price indexing. It protects workers against the erosion of benefits as a result of inflation. At the same time, while wage indexing only cuts the long-range deficit in half, price indexing reduces the deficit totally, placing the system in long-range actuarial balance. In this way, it makes unnecessary additional rate increases of 1.45 percent which will be required if wage indexing is adopted. Finally, it provides Congress with the flexibility to make appropriate adjustments in the level of benefits which will benefit not only present workers, but also those who have already retired.

IV. ALTERNATIVE METHODS ARE AVAILABLE FOR FINANCING SOCIAL SECURITY

My comments so far have been essentially negative. I have said what I do not think should be done. I believe the following proposals, together with price indexing, offer a more equitable and rational solution to the short- and long-range deficits of social security.

A. FEDERAL EMPLOYEES SHOULD BE COVERED BY SOCIAL SECURITY

Bringing Federal employees under social security would substantially contribute to meeting the $70 billion shortfall. The Social Security Administration has estimated that $33.7 billion would be raised for social security in the first 5 years Federal employees were covered. This is because in the first few years of coverage, many more employees would be paying into social security than would be drawing out benefits. Moreover, the Social Security Administration has estimated that bringing in Federal employees would reduce the long-range social security deficit in part as a result of eliminating the abuse known as double-dipping (the process which permits retired Federal employees to supplement their civil service pensions by working just enough years to qualify for the minimum social security benefit).

It is essential that Federal employees who are brought under social security not receive reduced benefits and not have to pay higher contributions. This result can be achieved by integrating the Federal retirement systems with social security, in the manner of many private pension plans. Indeed, I would only propose coverage of Federal employees if their aggregate benefits were not reduced and their aggregate contributions were no higher. This can be accomplished because the liabilities of the civil service retirement trust fund will be decreasing as social security benefits accrue.

Moreover, if Federal employees were brought under social security, their benefits would be slightly improved. Social security insures that employees and their families have adequate income not only at retirement but also in the event of disability or death. Although the civil service retirement system provides coverage in the event of disability or death, the coverage is not as complete as the social security coverage.

For example, civil service coverage does not begin until a worker has had 5 years of employment with the Government. In contrast, under social security, younger workers need less than 5 years of employment for coverage. Even after an employee has completed 5 years of service and becomes eligible for protection, many more years of service are required before survivorship protection for families and disability protection for a worker with dependents reaches the level provided under social security.

Inclusion of Federal employees under social security is consistent with the original intent of social security and has been recommended by every social security advisory group since 1938. With social security coverage, Federal employees will be no worse off than now and the system will come closer to its intended role as a universal floor of protection for all working Americans.

B. A SURCHARGE SHOULD BE IMPOSED ON CORPORATE AND PERSONAL INCOME TAXES

In my judgment, a surcharge on the corporate and personal income tax is the fairest and most equitable method of meeting the remainder of the social security deficit. This is a difficult recommendation for me to make because I am convinced that taxes are too high and impose too much of a burden on individuals and the economy.

I am committed to reducing taxes. I think it is the most important objective of "tax reform." Nevertheless, failure to insure the financial viability of the social security system is unthinkable. Therefore, the only question is who should bear the cost of providing the necessary revenue.

It is my view that the cost should be spread equitably throughout society rather than borne most heavily by only certain employers (raising the employers' base) or by low- and middle-income employees (raising the rate or the base on employees). The most equitable method of spreading the increased burden throughout society and yet retaining the identifiable character of a separate social security tax is a surcharge on the income tax.

A surtax is similar to the use of general revenues, but it has several advantages over the use of Treasury funds. It raises real dollars rather than simply increasing the deficit. It preserves the direct linkage between the individual and social security contributions. By retaining a link between the cost of social security and the benefits, there is no open invitation to "raid the Treasury" irresponsibly. Furthermore, a surtax encourages persons who are not covered under social security, like employees of some State and local governments, to join the system since they would already be contributing to it.

These three proposals taken together—inclusion of Federal employees, a 3-percent corporate and personal income tax and price indexing—leave the cash programs of social security in short-range and long-range actuarial balance. They are the most rational, fairest, and most equitable solution to the unpleasant and difficult task of raising $70 billion.

V. IF PAYROLL TAXES ARE USED TO FINANCE SOME OR ALL OF THE SOCIAL SECURITY DEFICIT, MEANINGFUL FISCAL RELIEF FOR STATE AND LOCAL GOVERNMENTS AND NONPROFIT ORGANIZATIONS MUST BE INCLUDED

The committee's social security tax proposals, together with already scheduled increases, will cause the social security taxes of State and local governments and nonprofit organizations to more than double in 5 years and to more than triple in 10 years—from an aggregate tax of $6.6 billion to a tax of $21.6 billion.

The financial crisis which confronts our cities and other governmental agencies is widespread and extremely serious. All too often we have witnessed the curtailment of essential municipal and educational services or strikes for higher wages by teachers, firefighters, and other governmental workers. The next tax proposal will only make the financial plight of our local governmental agencies worse.

In 1976, Toledo, Ohio, was forced to shut its schools for the month of December because of the city's financial condition. Similarly, Detroit laid off or eliminated positions for over 4,100 employees, reduced salaries by 8 percent in each department, cut funds for welfare services and prison care, and still projected a large 1976 deficit. On March 9, 1976, the New York Times began a story with the following disturbing lead:

"The City of Buffalo, which had been expected to run out of cash tomorrow, arranged to borrow $2 million today. . . . The loan will enable the city government and its Board of Education to meet their cash needs until Friday. . . ."

Many nonprofit organizations are facing similar financial crunches. The Young Women's Christian Association of the National Capital Area has sustained deficits averaging $50,000 in each of the last 7 years on an annual budget of $2 million. Colleges are struggling against ever increasing operating costs. Often tuition has been raised to the point where it is out of the financial reach of many students.

In this period of severe financial crisis for many nonprofit organizations, social security taxes will be raised by spectacular amounts. Two years from now, the American Cancer Society in Michigan, for example, will have an increase of over 25 percent in its social security tax liability under the committee's proposal. The University of Alabama in Tuscaloosa in 1981 will be paying $864,000 more than it paid last year, an increase of 50 percent. Similarly, Hampshire College in Amherst, Mass., in 1981 will be paying $107,287 more or an increase of 61 percent.

These organizations have little or no capability of passing on the increased cost. Moreover, unlike private, profitmaking employers, the additional social security tax payments will not be reflected in lower income taxes. As a result, these public and nonprofit employers will have to bear 100 percent of the increased liability themselves. They must either curtail their activities or raise more money, either through more contributions in the case of nonprofits or more local taxes in the case of public employers, to meet the full increased liability. In contrast, profitmaking employers will bear only a portion of the increase, the rest being an offset against Federal and State income tax liabilities which would otherwise be payable. Every increase profitmaking employers have in social security taxes translates into an operating cost of only a portion of the increase.

The committee has recognized the need for some tax relief for these employers as well as the basic inequity in tax treatment between these employers and for-profit employers. The committee has agreed to a refundable tax credit for these employers—a refund of a portion of their social security taxes from general revenues—but has adopted a clumsy mechanism which produces unfair and arbitrary results.

In order to receive a refund, an employer must pay its employees above the wage base. In 1979, the wage base will be close to $20,000 and will be over $30,000 by 1985.

As I have shown above, the bulk of the increase in the liability for this group of employers results from rate increases, not base increases.

Therefore, the refund in the committee proposal is of some help to well-endowed foundations and other employers with highly paid professional employees, but the vast majority of charitable employers will receive almost no benefit at all. In 1979, for example, the Salvation Army, covering Virginia, half of West Virginia, Washington, D.C., and part of Maryland, will pay social security taxes of almost $86,000—an increase of $13,000 over its present liability—and will receive a refund of $7.67. The Campfire Girls will receive nothing, because the organization will not be paying anyone over $19,500 in 1979, notwithstanding a tax increase of 40 percent. New Haven, Conn., will have to pay an additional $40,000 in social security tax but will receive no refund.

Moreover, even those employers who are benefited will only be benefited for a few years. The committee's proposal is designed to phase out just as the increases are beginning to really rise. As the future rate increases become effective and the employee wage base rises, the refund disappears. In 1987, for example, the costs to these employers will be up 227 percent; the refund will represent only 6 percent of this total.

These employers, unlike most, may under law voluntarily withdraw from social security, and they have been withdrawing at an accelerating rate. If New York City employees alone were to withdraw from social security, the trust funds would lose $3.1 billion in the next 4 years; 219 governmental units representing 81,534 employees have notices to withdraw currently pending before the Social Security Administration. If enough public and nonprofit employers withdrew, the tax increases could backfire, causing the trust funds to lose more revenue than they gained.

I agree with the majority of the committee that some sort of tax relief is needed for this group of employers. But the relief should be based on total liability, not on how much they pay their employees. It should be a permanent and stable refund, not a decreasing amount each year.

At a time when we are tripling the social security tax of these employers, I believe we should cushion the increase in some meaningful way. At a time when profitmaking employers will offset $23 billion in Federal income tax otherwise payable, I believe we can refund the public and nonprofit employers $1 billion, the approximate cost of a flat 10-percent refund of total social security tax liability.

JOHN C. DANFORTH.

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95th Congress } HOUSE OF REPRESENTATIVES { Report
1st Session } { No. 95–837

SOCIAL SECURITY AMENDMENTS OF 1977

December 15, 1977.—Ordered to be printed

Mr. Ullman, from the committee of conference,
submitted the following

CONFERENCE REPORT

[To accompany H.R. 9346]

The committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 9346) to amend the Social Security Act and the Internal Revenue Code of 1954 to strengthen the financing of the social security system, to reduce the effect of wage and price fluctuation on the system's benefit structure, to provide for the conduct of studies with respect to coverage under the system for Federal employees and for employees of State and local governments, to increase the earnings limitation, to eliminate certain gender-based distinctions and provide for a study of proposals to eliminate dependency and sex discrimination from the social security program, and for other purposes, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the Senate amendment insert the following:

That this Act, with the following table of contents, may be cited as the "Social Security Amendments of 1977".

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Sec. 361. Establishment of Commission.

PART G—MISCELLANEOUS PROVISIONS

Sec. 371. Appointment of hearing examiners.
Sec. 372. Report of Advisory Council on Social Security.

TITLE IV—PROVISIONS RELATING TO CERTAIN STATE WELFARE AND SERVICE PROGRAMS RECEIVING FEDERAL FINANCIAL ASSISTANCE

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Sec. 402. Incentive adjustments for a quality control in Federal financial participation in aid to families with dependent children programs.
Sec. 403. Access to wage information.
Sec. 404. State demonstration projects.
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TITLE V—MISCELLANEOUS

Sec. 501. Coverage under medicare of certain power-operated wheelchairs.
Sec. 502. Federal Election Campaign Act amendments.

TITLE I—PROVISIONS RELATING TO THE FINANCING OF THE OLD-AGE SURVIVORS, AND DISABILITY INSURANCE PROGRAM

ADJUSTMENTS IN TAX RATES

SEC. 101. (a)(1) Section 3101(a) of the Internal Revenue Code of 1954 (relating to rate of tax on employees for purposes of old-age, survivors, and disability insurance) is amended by striking out paragraphs (1) and (2) and inserting in lieu thereof the following:

"(1) with respect to wages received during the calendar years 1974 through 1977, the rate shall be 4.95 percent;

"(2) with respect to wages received during the calendar year 1978, the rate shall be 5.05 percent;

"(3) with respect to wages received during the calendar years 1979 and 1980, the rate shall be 5.08 percent;

"(4) with respect to wages received during the calendar year 1981, the rate shall be 5.35 percent;

"(5) with respect to wages received during the calendar years 1982 through 1984, the rate shall be 5.40 percent;

"(6) with respect to wages received during the calendar years 1985 through 1989, the rate shall be 5.70 percent; and

"(7) with respect to wages received after December 31, 1989, the rate shall be 6.20 percent.".

(2) Section 3111(a) of such Code (relating to rate of tax on employers for purposes of old-age, survivors, and disability insurance) is amended by striking out paragraphs (1) and (2) and inserting in lieu thereof the following:

"(1) with respect to wages paid during the calendar years 1974 through 1977, the rate shall be 4.95 percent;

"(2) with respect to wages paid during the calendar year 1978, the rate shall be 5.05 percent;

"(3) with respect to wages paid during the calendar years 1979 and 1980, the rate shall be 5.08 percent;

JOINT EXPLANATORY STATEMENT OF THE COMMITTEE OF CONFERENCE

The managers on the part of the House and the Senate at the conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 9346) to amend the Social Security Act and the Internal Revenue Code of 1954 to strengthen the financing of the social security system, to reduce the effect of wage and price fluctuation on the system's benefit structure, to provide for the conduct of studies with respect to coverage under the system for Federal employees and for employees of State and local governments, to increase the earnings limitation, to eliminate certain gender-based distinctions and provide for a study of proposals to eliminate dependency and sex discrimination from the social security program, and for other purposes, submit the following joint statement to the House and the Senate in explanation of the effect of the action agreed upon by the managers and recommended in the accompanying conference report:

The House recedes from its disagreement to the amendment of the Senate with an amendment which is a substitute for both the House bill and the Senate amendment. The differences between the House bill, the Senate amendment, and the substitute agreed to in conference are generally described below, except for technical, clerical, conforming, clarifying, and minor drafting changes.

ADJUSTMENTS IN TAX RATES

The House bill contained changes in the social security tax schedule necessary to finance the social security system as modified by the House bill, as shown in table 1.

TABLE 1.—SOCIAL SECURITY TAX RATES—HOUSE-PASSED BILL

[In percent]

Calendar year	OASI[1]	DI[1]	OASDI[1]	HI	Total
	Employees and employers, each				
1977	4.375	0.575	4.95	0.90	5.85
1978	4.275	.775	5.05	1.00	6.05
1979-80	4.300	.750	5.05	1.00	6.05
1981	4.450	.800	5.25	1.30	6.55
1982-84	4.550	.800	5.35	1.30	6.65
1985	4.750	.900	5.65	1.30	6.95
1986-89	4.750	.900	5.65	1.45	7.10
1990 and after	5.100	1.100	6.20	1.45	7.65
	Self-employed				
1977	6.185	0.815	7.00	0.90	7.90
1978	6.010	1.090	7.10	1.00	8.10
1979-80	6.045	1.055	7.10	1.00	8.10
1981	6.700	1.200	7.90	1.30	9.20
1982-84	6.850	1.200	8.05	1.30	9.35
1985	7.100	1.350	8.45	1.30	9.75
1986-89	7.100	1.350	8.45	1.45	9.90
1990 and after	7.650	1.650	9.30	1.45	10.75

[1] By allocation in the law.

The Senate amendment changed these provisions to finance the social security system as modified by the Senate amendment. The tax rates in the Senate amendment are shown in table 2.

TABLE 2.—SOCIAL SECURITY TAX RATES—SENATE-PASSED BILL

[In percent]

Calendar year	OASI [1]	DI [1]	OASDI	HI	Total
	Employees and employers, each				
1977	4.375	0.575	4.95	0.90	5.85
1978	4.275	.775	5.05	1.00	6.05
1979–80	4.335	.750	5.085	1.05	6.135
1981	4.525	.825	5.35	1.25	6.60
1982–84	4.575	.825	5.40	1.25	6.65
1985	4.750	.950	5.70	1.35	7.05
1986–89	4.750	.950	5.70	1.40	7.10
1990–94	5.100	1.050	6.15	1.40	7.55
1995–2000	5.500	1.200	6.70	1.40	8.10
2000–10	5.950	1.350	7.30	1.40	8.70
2011 and after	6.300	1.500	7.80	1.40	9.20
	Self-employed				
1977	6.185	0.815	7.0	0.90	7.90
1978	6.010	1.090	7.10	1.00	8.10
1979–80	6.010	1.040	7.05	1.05	8.10
1981	6.7625	1.2375	8.00	1.25	9.25
1982–84	6.7625	1.2375	8.00	1.25	9.25
1985	7.125	1.425	8.55	1.35	9.90
1986–89	7.125	1.425	8.55	1.40	9.95
1990–94	7.675	1.575	9.25	1.40	10.65
1995–2000	8.250	1.800	10.05	1.40	11.45
2001–10	8.925	2.025	10.95	1.40	12.35
2011 and after	9.950	2.250	11.70	1.40	13.10

[1] By allocation in law.

The House recedes with an amendment providing a new schedule of taxes to finance the system as modified by the conference agreement. The tax rates in the conference agreement are shown in table 3.

TABLE 3.—SOCIAL SECURITY TAX RATES

[In percent]

Calendar year	OASI [1]	DI [1]	OASDI	HI	Total
	Employees and employers, each				
1977	4.375	0.575	4.95	0.90	5.85
1978	4.275	.775	5.05	1.00	6.05
1979–80	4.330	.750	5.08	1.05	6.13
1981	4.525	.825	5.35	1.30	6.65
1982–84	4.575	.825	5.40	1.30	6.70
1985	4.750	.950	5.70	1.35	7.05
1986–89	4.750	.950	5.70	1.45	7.15
1990 and later	5.100	1.100	6.20	1.45	7.65
	Self-employed				
1977	6.1850	0.8150	7.00	0.90	7.90
1978	6.010	1.090	7.10	1.00	8.10
1979–80	6.0100	1.0400	7.05	1.05	8.10
1981	6.7625	1.2375	8.00	1.30	9.30
1982–84	6.8125	1.2375	8.05	1.30	9.35
1985	7.1250	1.4250	8.55	1.35	9.90
1986–89	7.1250	1.4250	8.55	1.45	10.00
1990 and later	7.6500	1.6500	9.30	1.45	10.75

[1] By allocation in law.

Allocation to Disability Insurance Trust Fund

The House bill would increase allocation to the disability insurance trust fund beginning in 1978. (See table 1 above.)

The Senate amendment would also increase allocation to the disability insurance trust fund beginning in 1978. (See table 2 above.)

The conference agreement modifies the allocation rates to finance the disability insurance program. (See table 3 above.)

CONTRIBUTION AND BENEFIT BASE

The House bill provided for 4 ad hoc increases in the contribution and benefit base for employees, employers, and the self-employed in 1978, 1979, 1980, and 1981. After 1981 the base would be automatically adjusted to keep up with average wage levels in the same way the present-law base is adjusted.

The Senate amendment provided for 4 ad hoc increases in the contribution and benefit base for employees and the self-employed of $600 each, above the level that would prevail under present law, in 1979, 1981, 1983, and 1985. After 1985, the base would be automatically adjusted to keep up with average wage levels.

The Senate amendment also provided for increasing the taxable earnings base for employers to $50,000 for 1979–84 and to $75,000 beginning in 1985. The base would remain at that level until the employee base reached that level, after which time both would be automatically adjusted.

The conference agreement follows the House bill except that no increase in the contribution and benefit base (over present law) is provided in 1978. Table 4 below shows the base for employers and employees under the House and Senate bills and the conference agreement. (Amounts shown under the Senate bill depend, in part, on automatic adjustments and are, therefore, estimates.)

TABLE 4.—CONTRIBUTION AND BENEFIT BASE

Calendar year	House-passed bill	Senate-passed bill		Conference agreement
		Employee, self-employed	Employer	
1978	$19,900	$17,700	$17,700	$17,700
1979	22,900	19,500	50,000	22,900
1980	25,900	21,000	50,000	25,900
1981	29,700	23,100	50,000	29,700
1982	(1)	(2)	(3)	(1)

[1] Automatic thereafter.

[2] Employee base, including $600 increases in 1983 and 1985, estimated to rise to $24,600 for 1982, $26,700 for 1983, $28,200 for 1984, $30,300 for 1985, with automatic increases (as under present law) thereafter.

[3] Remains at $50,000 through 1984; increases to $75,000 in 1985 and remains at $75,000 until employee base reaches $75,000.

Railroad Retirement tier-II.—Under the House bill, the tax base for tier-II of the Railroad Retirement Act for both benefits and tax purposes would be the same as under the automatic-increase provisions of the present law and would not be affected by increases in the social security taxable wage base contained in the bill. Under the Senate amendment the tax base for tier-II of the Railroad Retirement Act would not be affected but the amount of earnings used for computing the tier-II benefit would be the base used for social security benefits under the amended law.

The Senate recedes.

Pension Benefit Guaranty Corporation (*PBGC*).—The House bill provided that the pension insurance administered by PBGC would not be affected by the ad hoc increases in the wage base under social security. The insured pension amount would increase as it would under automatic-increase provisions of present law.

The Senate bill contained no similar provision.

The Senate recedes.

STANDBY GUARANTEE OF TRUST FUND LEVELS

The House bill provided standby authority for automatic loans to the OASDI trust funds from Federal general revenues whenever the assets of a cash benefits trust fund at the end of a calendar year amount to less than 25 percent of the outgo from the fund in the calendar year. The amount of the loan would be equal to the difference between the year-end balance in the fund and 27½ percent of the year's outgo.

Such loans would automatically be repaid with interest when assets at the end of a year exceeded 30 percent of the year's outgo from the fund. To provide for automatic repayment, there would be temporary social security tax-rate increases of 0.1 percent for employees and employers, each, and 0.15 percent for the self-employed, if at the end of any year after the year the loan was made the reserve level is less than 35 percent and the loan debt exceeds $2 billion. This temporary tax rate increase would go into effect one year later.

The standby loan authority would not be applicable for the HI trust fund.

The Senate amendment contained no such provision.

The House recedes.

REDUCTION IN TAXES FOR CERTAIN EMPLOYERS

The Senate amendment would limit State and local governmental and 501(c)(3) nonprofit employers' social security liability for 1979 to the liability that would be incurred for 1979 under the provisions of present law. For 1980 and after, such an employer's liability (in dollars) would generally be 90 percent of the liability under the law as amended by the bill, but not less than the 1979 liability. In no case would the provision require an increase in liability as compared with the regular provisions applicable to other employers. An authorization for appropriations from general revenues is provided to make up the loss of social security revenue to the trust funds that would result from enactment of the provision.

The House bill contained no such provision.

The Senate recedes.

MODIFICATION OF BENEFIT FORMULA

Both the Senate amendment and the House bill provided for basic changes in the computation of social security benefits for workers reaching age 62 after 1978. Although the provisions of the two bills were very similar, there were differences, described below:

BENEFIT FORMULAS

The House bill provided for a benefit formula producing benefit amounts roughly 5 percent lower than estimated present-law benefits at implementation (January 1, 1979). The formula for relating maximum family benefits to primary insurance amounts (PIA's) has a similar effect.

The Senate amendment benefit formula produced benefit amounts roughly equivalent to 1976 levels—about 2½ percent lower than estimated present-law benefits at implementation. The formula for relating maximum family benefits to PIA's had a similar effect.

The Senate recedes.

TRANSITIONAL PERIOD

The House bill provided a 10-year guarantee of benefit amounts based on the benefit table as of December 1978 in retirement cases.

The Senate amendment provided a 5-year guarantee in retirement cases.

The House recedes.

MINIMUM BENEFIT

Under the House bill, the December 1978 minimum benefit rounded to the next higher dollar (estimated to be about $121) would have been frozen for new beneficiaries. The minimum would have been increased in line with CPI increases only after a worker reached age 62, became disabled, or died.

The Senate amendment was similar except that it would have increased the minimum by CPI increases beginning with the year in which the individual (a worker, his widow, or child) actually became entitled to benefits, rather than from the point at which the worker reached age 62 became disabled, or died.

The House recedes with an amendment under which CPI increases for a worker or aged widow or widower generally would not begin to apply until the earlier of: (a) the first year the worker or aged widow (widower) was paid part or all of the benefits to which he was entitled for that year, after application of the retirement test; (b) the year of attainment of age 65.

SPECIAL MINIMUM

The House bill provided for an increase in the special minimum benefit up to a maximum of $230 a month for a worker ($345 for a couple) with 30 years of coverage under social security. The special minimum is calculated by multiplying $9 ($11.50 under the House bill) times the number of years of coverage (years in which earnings were at least 25% of the contribution and benefit base) in excess of 10 and up to 30—for a maximum multiplier of 20. Years of coverage would be based on the base as increased automatically by rises in average wages (without ad hoc increases as a result of H.R. 9346). Special minimum benefits would be increased automatically by CPI increases in the future.

The Senate amendment contained no such provision.

The Senate recedes.

DELAYED RETIREMENT CREDIT

The House bill provided for an increase in the delayed retirement credit to one-fourth of 1 percent for each month (3 percent per year) for which a worker does not receive a benefit between ages 65 and 72, for persons attaining age 62 after 1978.

The Senate amendment contained no such provision.

The Senate recedes.

DELAYED RETIREMENT CREDIT FOR WIDOWS AND WIDOWERS

The Senate amendment included a provision which would make the delayed retirement credit applicable to widow's and widower's insurance benefits, as well as to the worker's benefit.

The House bill contained no such provision.

The House recedes with an amendment making the change effective with June 1978.

LIBERALIZATION OF THE EARNINGS TEST

The House bill increased the exempt amount under the earnings test for beneficiaries age 65 and over to: $4,000 in 1978; $4,500 in 1979; $5,000 in 1980; and $5,500 in 1981.

The Senate amendment increased the exempt amount to $4,500 in 1978 and $6,000 in 1979 for all beneficiaries.

The Senate recedes adopting the exempt amounts in the House bill and increasing the exempt amount to $6,000 in 1982. These increases would apply only to beneficiaries age 65 and over.

AGE AT WHICH EARNINGS TEST NO LONGER APPLIES

The House bill lowered the age at which the retirement test no longer applies from age 72 to age 65 in 1982.

The Senate amendment lowered the age at which the retirement test no longer applies from age 72 to age 70 in 1982.

The House recedes.

LIBERALIZATION OF THE FOREIGN WORK TEST

The House bill provided for payment of benefits for any month in which a beneficiary engaged in noncovered work outside the United States worked 8 or fewer days in 1978, and 11 or fewer days in 1979 and thereafter.

The Senate amendment contained no such provision.

The House recedes.

STUDIES OF MANDATORY COVERAGE

The House bill required joint studies by the Office of Management and Budget, the Civil Service Commission, the Department of the Treasury, and the Department of Health, Education and Welfare of mandatory coverage for Federal and State and local employees with reports and recommendations to the President and Congress within 2 years of enactment.

The Senate amendment contained no such provision.

The Senate recedes with amendments which would combine the studies of mandatory coverage of employees of Federal, State, and local governments and nonprofit organizations; would require the Secretary of Health, Education, and Welfare to conduct the study with appropriate consultation with Treasury, the Office of Management and Budget, and the Civil Service Commission.

The managers anticipate that the study will include, in addition to the evaluation of alternative proposals, examination of the following specific items: (1) Analysis of any possible constitutional questions involved in extensions of coverage; (2) review of the extent of State, local and nonprofit coverage under existing law; (3) analysis of the economic impact on State and local governments of mandatory coverage extensions; and (4) an analysis of the feasibility of developing a method of covering Federal employees without increasing their contributions or adversely affecting their benefit rights (except to the extent that any windfall benefit situations may be eliminated).

COVERAGE OF NONPROFIT ORGANIZATIONS

The Senate amendment included provisions to: (1) forgive through June 30, 1977, the social security tax liability of nonprofit organizations that stopped paying social security taxes before October 19, 1976, because they had not filed the proper certificate with the Internal Revenue Service to cover their employees under social security: (2) extend the deadline for filing waiver certificates for organizations that obtained refunds prior to Septemper 9, 1976; (3) permit nonprofit organizations that paid social security taxes while waiting for the Internal Revenue Service to approve their request for tax-exempt status to receive a refund of those taxes in spite of P.L. 94–563 under which the taxes and social security coverage that resulted were validated; and (4) not require nonprofit organizations that received a refund of social security taxes for April-June 1973, to bring their employees under social security coverage.

The House bill contained no such provisions. (The Ways and Means Committee had reported a bill, H.R. 8490, that contained similar provisions.)

The House recedes with technical clarifying amendments.

LIMITED PARTNERSHIP INCOME

The House bill excluded from coverage the distributive share of income or loss received by a limited partner.

The Senate amendment contained no such provision.

The Senate recedes.

EMPLOYEES OF MEMBERS OF RELATED GROUPS OF CORPORATIONS

The Senate amendment provided that a group of corporations concurrently employing an individual would be considered as a single employer if one of the group serves as a common paymaster for the entire group. This would result in such corporations having to pay no more in social security and unemployment taxes than a single employer pays.

The House bill contains no such provision.

The House recedes with clarifying amendments.

The provision limits the aggregate amount of employment taxes due for any taxable year with respect to an individual concurrently employed by two or more related corporations and compensated through a common paymaster which is itself one of the corporations employing the individual and which would have the responsibility for making payment to the Internal Revenue Service of employment taxes due. The provision is intended to establish a maximum total liability for the related corporations (including the common paymaster) as a group but is not intended to relieve any corporation of ultimate liability for any portion of the total amount of employment taxes due. The provision is not intended to have any effect on the deductibility for Federal income tax purposes of employment taxes or wages payable by a corporation; accordingly, since the corporation for which services are performed is the only one eligible to deduct wages and employment taxes paid with respect to such services, such wages and taxes will not be deductible unless the corporation for which the services are performed reimburses the common paymaster for such payments. For purposes of determining income tax deductions allowable, the conferees expect the Secretary of the Treasury to establish procedures for allocating employment taxes among related corporations establishing a common paymaster.

EMPLOYER TAXES ON TIPS

The House bill included a provision to require employers to pay social security taxes on tips deemed to be wages under the Federal minimum wage law.

The Senate amendment contained no such provision.

The Senate recedes with the understanding that the employer will be liable for the employer social security tax on the tips that are deemed wages, regardless of the amount of the tips the employee reports under section 6053(a) of the Internal Revenue Code of 1954.

COVERAGE FOR CLERGYMEN

The House bill permitted clergymen who filed application for exemption from coverage to revoke their exemption (but only during a limited period of time).

The Senate amendment contained no such provision.

The Senate recedes.

TOTALIZATION AGREEMENT

The House bill authorized the President to enter into bilateral agreements with foreign countries to provide the limited coordination of social security systems. Each such agreement would have to be transmitted to the Congress and could not go into effect until 90 days after one House had been in session. During that period an agreement could be rejected by action of both Houses enacting legislation.

The Senate amendment included the same provision except that: Each agreement must be transmitted to Congress with a report on estimated cost and number of individuals affected; an agreement must not be inconsistent with the provisions of title II of the Social Security Act; an agreement could not go into effect until 90 days after both Houses of Congress had been in session during which period an agreement could be rejected by action of either House.

The House recedes.

ILLINOIS POLICEMEN AND FIREMEN

The House bill included a provision which would validate earnings erroneously reported for policemen and firemen covered under the Illinois Municipal Retirement Fund.

The Senate amendment contained no such provision.

The Senate recedes with an amendment that coverage for future periods would be provided for the policemen and firemen affected.

WISCONSIN RETIREMENT FUND

The House bill provided that a special coverage provision applicable to members of the Wisconsin Retirement Fund would be applicable to any successor system of that fund.

The Senate amendment contained no such provision.

The Senate recedes.

LIMITATION ON RETROACTIVE BENEFITS

The House bill provided that benefits would not be paid retroactively for months before an application is filed, when such payment results in a permanent reduction of future monthly benefits, effective January 1, 1978.

The Senate amendment was similar to the House provision except that it was effective upon enactment, rather than on January 1, 1978.

The Senate recedes.

DELIVERY OF BENEFIT CHECKS

The House bill required that whenever the delivery date for payment of either social security or supplemental security income checks falls on a Saturday, Sunday, or legal public holiday, the checks would be mailed "and delivered" on an earlier date. Any overpayment that occurs as a direct result of the earlier delivery of checks would be waived and would not be subjected to recovery.

The Senate amendment required in such circumstances that checks be "mailed for delivery" on the earlier date and did not include the waiver of overpayment provision of the House bill.

The Senate recedes with an amendment providing that checks be "mailed for delivery" by the earlier date.

REDUCED BENEFITS FOR SPOUSES RECEIVING GOVERNMENT PENSIONS

The Senate amendment provided that social security dependents' benefits payable to spouses and surviving spouses would be reduced by the amount of any public (Federal, State, or local) retirement benefit payable to the spouse based on the spouses' own work in noncovered public employment. The provision would have been effective with respect to benefits payable for months beginning with the month of enactment, based on applications filed in or after the month of enactment.

The House bill contained no such provision.

The House recedes with an amendment which would provide for an exception for certain people who are already receiving pensions based on noncovered public employment (or who would be eligible for such pension within 5 years of the month of enactment) and who could have expected to receive social security benefits as dependents or survivors under the social security law as in effect on January 1, 1977. The managers are concerned that there may be large numbers of women, especially widows in their late fifties, who are already drawing pensions, or would be eligible to draw them within 5 years of the date of enactment of this bill, based on their non-covered work and whose retirement income was planned for on the assumption of the availability of full wife's or widow's benefits under social security. Inclusion of this exception to the applicability of the Senate provision, reinforces its prospective nature and avoids penalizing people who are already retired, or close to retirement, from public employment and who cannot be expected to readjust their retirement plans to take account of the "offset" provision that will apply in the future.

A separability clause is included for the exception clause established by the conference agreement so that if it is found invalid the pension-offset as passed by the Senate would not be affected, and the application of the exception clause would not be broadened to include persons or circumstances that are not included within it.

Repeal of Workmen's Compensation Offset

The Senate amendment repealed the provision of existing law which provides for a reduction in social security disability benefits for persons simultaneously entitled to workmen's compensation payments where the combined payments would otherwise exceed 80 percent of recent predisability earnings.

The House bill contained no such provision.

The Senate recedes.

Disability Benefits for Blind Persons

The Senate amendment provided for paying disability insurance benefits for blind people who have at least six quarters of social security coverage. The benefits would be paid regardless of the amount of an individual's earnings both before and after age 65 or his ability to work. The Senate amendment also excluded blind persons from the requirements of present law that disability benefits be suspended for any months during which a beneficiary refuses without good cause to accept vocational rehabilitation services.

The House bill contained no such provision.

The House recedes with an amendment which strikes the provisions of the Senate amendment but provides that the amount of earnings under the test of substantial gainful activity (SGA) which would terminate (or suspend for those age 55 or over) a blind individual's benefits would be increased to the monthly exempt amounts for persons 65 and over under the retirement test. The conferees are aware that this establishes a different test of SGA for blind persons than is applied administratively for persons with other disabilities. The conferees do not intend that the new SGA level established for the blind should be applied to other types of disability.

ELIMINATION OF MARRIAGE OR REMARRIAGE AS A FACTOR IN ENTITLEMENT TO, OR TERMINATION OR REDUCTION OF, BENEFITS

The House bill provided that marriage or remarriage would not bar or terminate entitlement to benefits as a divorced spouse, surviving spouse (including those caring for an entitled child), parent, or child, and remarriage would not cause any reduction in aged widow's or widower's insurance benefits.

The Senate amendment did not include such a provision.

The Senate recedes, with an amendment that would retain only that part of the House-passed provisions that would prevent reduction in benefits for widows and widowers who remarry after age 60.

DURATION-OF-MARRIAGE REQUIREMENT

The House bill provided that the length of time a person must have been married to a worker in order for benefits to be payable to the person as an aged divorced spouse or surviving divorced spouse would be reduced from 20 years to 5 years.

The Senate amendment did not include such a provision.

The Senate recedes, with an amendment which establishes a 10-year duration-of-marriage requirement.

EQUALIZATION OF TREATMENT OF MEN AND WOMEN UNDER THE PROGRAM

The House bill contained a number of amendments that were designed to eliminate certain gender-based distinctions from the social security program.

The Senate amendment did not include any such provisions.

The House recedes. It is the understanding of the managers that the entire question of such gender-based distinctions will be included in the 6-month study of proposals to eliminate dependency and sex discrimination provided by this legislation.

ANNUAL REPORTING

The House bill included provisions to simplify implementation of annual wage reporting.

The House provision changes the provisions of the Social Security Act that require the use of quarterly wage data so that only annual data would be needed—employers would no longer have to check off quarters of coverage or report quarterly wages on the forms W–2.

It excludes from the definition of wages certain employment wherein the remuneration is less than $100 in a calendar year. State and local employers will continue to report on a quarterly basis but wages will be converted to annual figures. The provision also changes "quarter of coverage" definition so that after 1977 all workers would receive a quarter of coverage for each $250 of wages paid in a year (to a maximum of four quarters of coverage in a year). The amounts measuring a quarter of coverage would increase automatically each year as wages increase.

The Senate amendment contained no such provisions.

The Senate recedes.

NATIONAL COMMISSION ON SOCIAL SECURITY

The House bill provided for a nine-member National Commission on the Social Security Program, appointed by the executive and legislative branches, to conduct a 2-year study including: The fiscal status and adequacy of the trust funds; the scope of coverage, adequacy of benefits, conditions of qualification for benefits (including inequities arising out of marital status, sex, or similar classifications or categories), and quality of administration; the impact of the programs on and relation to public assistance programs, nongovernmental pension insurance programs, other governmental retirement and annuity programs, medical service delivery systems and national employment practices; and alternatives to current programs including, phasing out payroll tax, using general revenues or other financing, mandatory participation in private insurance programs and choice of public or private programs or both.

The Senate amendment did not include a provision comparable to the House provision.

The Senate recedes with an amendment which requires the National Commission to study the need to develop a special CPI for the elderly for purposes of social security cost-of-living increases.

ADMINISTRATIVE LAW JUDGES (HEARING EXAMINERS)

The Senate amendment converted the temporary administrative law judges established by Public Law 94–202 to permanent status under the Administrative Procedure Act.

The House bill contained no such provision, but the Ways and Means Committee has reported H.R. 5723 which contains identical language.

The House recedes.

ADVISORY COUNCIL ON SOCIAL SECURITY

The Senate amendment provided that the Advisory Council on Social Security to be appointed by December 31, 1977, would have an additional 9 months in which to submit its reports. The reports would be due October 1, 1979, rather than January 1, 1979.

The House bill contained no such provision.

The House recedes.

SEMIANNUAL COST-OF-LIVING INCREASES

The Senate amendment provided for semiannual cost-of-living increases in social security and SSI benefits whenever the CPI increased by at least 4 percent over a specified 6-month measuring period (an annual rate of over 8 percent per year).

The House bill contains no such provision.

The Senate recedes.

FISCAL RELIEF FOR WELFARE COSTS

The Senate amendment provided for a one-time payment to the States of $374 million as fiscal relief for State and local welfare costs for fiscal year 1978. Half of such funds would be distributed to each State in proportion to its share of total expenditures under the AFDC program for December 1976, and half would be distributed under the general revenue sharing formula. In those States in which local units of Government are responsible for meeting part of the costs of the AFDC program the fiscal relief payments would have to be passed through to local governments. States would not be required to pass through an amount in excess of 90 percent of the amount of AFDC costs for which the local government was otherwise responsible.

The House bill contained no such provision.

The House recedes with the following amendments. The amount of the one-time payment would be one-half of the amount in the Senate bill, that is, $187 million. Also States would be required to pass through to local jurisdictions the full amount of the payment but not more than 100 percent of the amount of the AFDC costs for which the local government was otherwise responsible.

FISCAL INCENTIVES FOR LOWERING AFDC ERROR RATES

The Senate amendment established a system of fiscal incentives for States which have low dollar error rates (below 4 percent) as measured by the AFDC quality control findings of excess payments.

Under the amendment States which have dollar error rates of, or reduce their dollar error rates to, less than 4 percent but not more than 3.5 percent of the total expenditures would receive 10 percent of the Federal share of the money saved, as compared with the Federal costs of 4-percent payment error rate. This percentage would increase proportionately as shown in the following table:

If the error rate is:	*Incentive Percentage*[1]
At least 3.5 percent but less than 4 percent	10
At least 3 percent but less than 3.5 percent	20
At least 2.5 percent but less than 3 percent	30
At least 2 percent but less than 2.5 percent	40
Less than 2 percent	50

[1] The State will retain this percent of the imputed Federal savings.

The House bill contained no such provision.

The House recedes with an amendment which provides that the dollar error rate of aid will include the payments to ineligibles plus overpayments plus underpayments plus the amount which would have been paid as benefits if the case had not been erroneously terminated or the application erroneously denied. The incentive would be based on Federal savings as compared with a 4-percent rate of excessive payments—that is, erroneous payments for ineligibles and overpayments.

ACCESS BY AFDC AGENCIES TO WAGE RECORDS

The Senate amendment specifically authorized State AFDC agencies to obtain wage information from the wage records maintained by the Social Security Administration and the wage records maintained by State unemployment compensation agencies for purposes of determining eligibility for (or amount of) AFDC. The Secretary of HEW would establish the necessary safeguards to prevent the improper use of such information. Effective October 1, 1979, States would be required to request and make use of this wage information either from the State unemployment compensation agency (if available there) or from the Social Security Administration.

The House recedes.

STATE WELFARE DEMONSTRATION PROJECTS

The Senate amendment would authorize certain types of State demonstration projects related to the AFDC program to be implemented if the Secretary did not specifically disapprove the implementation of such projects within forty-five days after the State applies to have the projects approved. In other words, a State could proceed with such projects either when the Secretary approved them, or forty-five days after submitting them to the Secretary if no decision had been reached by HEW within that period.

Under this authority, States would be permitted to conduct not more than three demonstration projects but not more than one on a Statewide basis. Projects involving public service employment would have to meet reasonable standards related to health, safety and other conditions, could not displace employed workers, would have to be reasonable for the individuals participating, and would have to provide appropriate workmen's compensation protection. Participation in any project by any AFDC recipient would have to be on a voluntary basis.

States would be permitted to waive ordinary statutory rules requiring statewide uniformity, administration by a single agency, and regarding participation in the work incentive program and the disregard of certain amounts of earned income. (Not more than half of all income could be disregarded under the waiver authority, however.)

AFDC matching for these demonstration projects would be limited to the amount the State would have received through AFDC if it had not implemented the demonstration project. In addition the State's general revenue sharing funds could be used to cover the costs of salaries for participants in public service employment which are not covered by AFDC matching.

Once implemented, demonstration projects could continue for up to 2 years unless the Secretary took action to disapprove a State waiver of statutory rules before the end of the 2-year period. The provision would not apply after September 30, 1980.

The House bill contained no such provisions.

The House recedes with an amendment. The conference agreement provides that when a State submits an application it would be required to make a public announcement that such application has been made, make copies of the application available and receive public comments for at least 30 days. The Secretary would also be required to publish a summary of the proposed demonstration project and make copies of the application available. He would receive public comments for at least 30 days after publication of a summary of the proposed project (even if the application is approved prior to the 30-day period).

The Secretary of HEW could deny applications by a State under this provision any time after receipt of the application, but could not approve an application until 30 days after it has been submitted.

A State would be authorized to proceed with projects submitted under this new authority 60 days, instead of 45 days under the Senate amendment, after the project application is submitted to HEW unless there is a specific disapproval by HEW.

The conference agreement also requires that when AFDC funds are used to pay wages of participants in such projects that the prevailing wage must be paid.

AFDC EARNED INCOME DISREGARD

The Senate amendment changed the earned income disregard so as to require States to disregard the first $60 earned monthly by an individual working full-time ($30 in the case of an individual working part-time), plus one-third of the next $300 earned, plus one-fifth of the remainder. Child care expenses would be subject to limitations by the Secretary and would be deducted before computing an individual's earned income. Other work expenses would not be deducted.

The House bill contained no such provisions.

The Senate recedes.

ERRONEOUS STATE SUPPLEMENTARY PAYMENTS

The Senate amendment provided authorization and direction for the Secretary of Health, Education, and Welfare to reimburse a State for erroneous State supplementary payments administered by them and paid during 1974 to the extent that an HEW audit determines is appropriate on the basis that the incorrect payments for the aged, blind, and disabled resulted from a State's good faith reliance upon erroneous or incomplete information furnished to the States by the Department or from a State's good faith reliance on incorrect supplemental security income payments made by the Department.

The House bill contains no such provision.

The House recedes with an amendment. The conference agreement provides that the Secretary of HEW would rely on findings of an audit by HEW which has been reviewed and concurred in by the Inspector General of the Department to determine the extent of payments under this provision.

VETERANS' PENSION AND COMPENSATION

The Senate amendment provided that the amount of any social security benefits resulting from a cost-of-living increase will not be used to reduce veterans' pension and compensation.

The House bill contained no such provision.

The Senate recedes.

MEDICARE COVERAGE OF DEVICES SERVING THE SAME PURPOSE AS A WHEELCHAIR

The Senate amendment expands the definition of durable medical equipment under the medicare supplementary medical insurance program to include specialized transportation vehicles (such as the *Amigo* wheelchair) designed to "serve the same or similar purpose as that performed by a wheelchair."

The House bill contains no such provision.

The House recedes with an amendment which expands the definition of durable medical equipment to include a power-operated vehicle that may be appropriately used as a wheelchair where such vehicle is determined to be medically necessary and meets safety requirements prescribed by the Secretary.

FEDERAL ELECTION CAMPAIGN ACT AMENDMENT

The Senate amendment provided that a contribution to a tax-exempt organization selected by the payor from a list of five or more organizations named by the government officer or employee would not be treated as an honorarium. It also provided that amounts returned to a payor before the end of the calendar year would not be treated as honorariums. The amendment further provided that honorariums would be treated as accepted in the year of receipt.

The House bill contained no such provision.

The House recedes.

COLLEGE TUITION TAX RELIEF

The Senate amendment modified the Internal Revenue Code to provide an income tax credit for educational expenses (tuition, fees, books, and equipment, but not meals, lodging, nor other living expenses) paid by the taxpayer for the taxpayer or the taxpayer's spouse or dependents to an institution of higher education or a vocational school. The amount of the credit would be limited each year to not more than $250 per student. The credit would apply to expenses paid in taxable years beginning after December 31, 1977; for 1978 only, it would be refundable. The student must be a full-time student working toward a baccalaureate degree or a certificate of required course work at a vocational school. Expenses eligible for the credit would be reduced by tax-exempt scholarship or fellowship grants and by certain educational assistance allowances and education and training allowances.

The House bill contained no such provision.

The Senate recedes.

Al Ullman,
James A. Burke,
Dan Rostenkowski,
Joe D. Waggonner, Jr.,
William R. Cotter,
Abner J. Mikva,
Jim Guy Tucker,
Managers on the Part of the House.
Russell B. Long,
Abraham Ribicoff,
Gaylord Nelson,
W. D. Hathaway,
Daniel Moynihan,
Carl T. Curtis,
Bill Roth,
John C. Danforth,
Managers on the Part of the Senate.

○

Finder's Aid

P.L. 95-292 (92 Stat. 307) Approved June 13, 1978

Subject	SS Act Section	P.L. Section	92 Stat.	H.Rep. 95-549	S.Rep. 95-714
Technical Amendment	226(a)	3(a)	315	—	—
Technical Amendment	226(e)	1(b)	308	—	—
Technical Amendment	226(e)(2)(3)	3(b)	315	—	—
Technical Amendment	226(f)	1(b)	308	—	—
Technical Amendment	226(g)	1(b)	308	—	—
Technical Amendment	226(h)	1(b)	308	—	—
Technical Amendment	226(i)	1(b)	308	—	—
Defines Medicare Coverage of End-Stage Renal Disease	226A	1	307	2-22	1-3
Description of Part A--HI Coverage Renal Disease--(Technical Amendment)	1811	4(a)	315	—	—
Incentive Reimbursement (Technical Amendment)	1814(b)(1)	4(f)	315	2-4	3
Secretary of Board of Trustees is HCFA Administrator (HI Trust)--(Technical Amendment)	1817(b)	5	315	5	—
Incentive Reimbursement--(Technical Amendment)	1833(a)(1)(C)(D)(E)	4(b)	315	2-4	3
Technical Amendment	1833(a)(2)	4(c)	315	—	—
HCFA Administrator Supplants SSA Commissioner as Secretary Medical Insurance Trust Fund	1841(b)	5	315	5	4
Add Home Dialysis Equipment--(Technical Amendment)	1861(s)(2)(F)	4(d)	315	—	5
Technical Amendment	1866(a)(2)(A)	4(e)	315	—	—
Technical Amendment	1876(b)(2)(B)	5	315	—	—
"Improved" Medicare Coverage--Renal Disease	1881	2	308	2-22	1-17
Medicaid Intensive Care Facility (ICF) Provision Re Patient's Funds--(Technical Amendment)	1905(c)	8(b)	316	—	18

11

Public Law 95-292
95th Congress

An Act

June 13, 1978
[H.R. 8423]

To amend titles II and XVIII of the Social Security Act to make improvements in the end stage renal disease program presently authorized under section 226 of that Act, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) title II of the Social Security Act is amended by inserting immediately after section 226 the following new section:

Social Security Act, amendment. End stage renal disease program. 42 USC 401 *et seq.* 42 USC 426.

"SPECIAL PROVISIONS RELATING TO COVERAGE UNDER MEDICARE PROGRAM FOR END STAGE RENAL DISEASE

42 USC 426-1. 42 USC 1395 *et seq.*

"SEC. 226A. (a) Notwithstanding any provision to the contrary in section 226 or title XVIII, every individual who—

42 USC 414. 42 USC 231 *et seq.*

"(1)(A) is fully or currently insured (as such terms are defined in section 214 of this Act) or would be fully or currently insured if his service as an employee (as defined in the Railroad Retirement Act of 1974) after December 31, 1936, were included in the term 'employment' as defined in this Act, or (B) is entitled to monthly insurance benefits under title II of this Act or an annuity under the Railroad Retirement Act of 1974, or (C) is the spouse or dependent child (as defined in regulations) of an individual who is fully or currently insured or would be fully or currently insured if his service as an employee (as defined in the Railroad Retirement Act of 1974) after December 31, 1936, were included in the term 'employment' as defined in this Act, or (D) is the spouse or dependent child (as defined in regulations) of an individual entitled to monthly insurance benefits under title II of this Act or an annuity under the Railroad Retirement Act of 1974;

"(2) is medically determined to have end stage renal disease; and

"(3) has filed an application for benefits under this section;

shall, in accordance with the succeeding provisions of this section, be entitled to benefits under part A and eligible to enroll under part B of title XVIII, subject to the deductible, premium, and coinsurance provisions of that title.

42 USC 1395. 42 USC 1395j.

"(b) Subject to subsection (c), entitlement of an individual to benefits under part A and eligibility to enroll under part B of title XVIII by reasons of this section on the basis of end stage renal disease—

"(1) shall begin with—

"(A) the third month after the month in which a regular course of renal dialysis is initiated, or

"(B) the month in which such individual receives a kidney transplant, or (if earlier) the first month in which such individual is admitted as an inpatient to an institution which is a hospital meeting the requirements of section 1861(e) (and such additional requirements as the Secretary may prescribe under section 1881(b) for such institutions) in preparation for or anticipation of kidney transplantation, but only if such transplantation occurs in that month or in either of the next two months,

42 USC 1395x. *Post*, p. 308.

whichever first occurs (but no earlier than one year preceding the month of the filing of an application for benefits under this section); and

"(2) shall end, in the case of an individual who receives a kidney transplant, with the thirty-sixth month after the month in which such individual receives such transplant or, in the case of an individual who has not received a kidney transplant and no longer requires a regular course of dialysis, with the twelfth month after the month in which such course of dialysis is terminated.

"(c) Notwithstanding the provisions of subsection (b)—

"(1) in the case of any individual who participates in a self-care dialysis training program prior to the third month after the month in which such individual initiates a regular course of renal dialysis in a renal dialysis facility or provider of services meeting the requirements of section 1881(b), entitlement to benefits under part A and eligibility to enroll under part B of title XVIII shall begin with the month in which such regular course of renal dialysis is initiated;

Infra.
42 USC 1395.
42 USC 1395j.

"(2) in any case in which a kidney transplant fails (whether during or after the thirty-six-month period specified in subsection (b)(2)) and as a result the individual who received such transplant initiates or resumes a regular course of renal dialysis, entitlement to benefits under part A and eligibility to enroll under part B of title XVIII shall begin with the month in which such course is initiated or resumed; and

"(3) in any case in which a regular course of renal dialysis is resumed subsequent to the termination of an earlier course, entitlement to benefits under part A and eligibility to enroll under part B of title XVIII shall begin with the month in which such regular course of renal dialysis is resumed.".

42 USC 426.

(b) Section 226 of such Act is amended—

(1) by striking out subsections (e), (f), and (g), and

(2) by redesignating subsections (h) and (i) as subsections (e) and (f), respectively.

42 USC 1395x.

SEC. 2. Part C of title XVIII of the Social Security Act is amended by adding at the end thereof the following new section:

"MEDICARE COVERAGE FOR END STAGE RENAL DISEASE PATIENTS

42 USC 1395rr.
42 USC 1395.
42 USC 1395j.
Ante, p. 307.

"SEC. 1881. (a) The benefits provided by parts A and B of this title shall include benefits for individuals who have been determined to have end-stage renal disease as provided in section 226A, and benefits for kidney donors as provided in subsection (d) of this section. Notwithstanding any other provision of this title, the type, duration, and scope of the benefit provided by parts A and B with respect to individuals who have been determined to have end-stage renal disease and who are entitled to such benefits without regard to section 226A shall in no case be less than the type, duration, and scope of the benefits so provided for individuals entitled to such benefits solely by reason of that section.

"(b)(1) Payments under this title with respect to services, in addition to services for which payment would otherwise be made under this title, furnished to individuals who have been determined to have end-stage renal disease shall include (A) payments on behalf of such individuals to providers of services and renal dialysis facilities which meet such requirements as the Secretary shall by regulation prescribe for institutional dialysis services and supplies (including self-dialysis services in a self-care dialysis unit maintained by the provider or facility), transplantation services, self-care home dialysis support services which are furnished by the provider or facility, and routine professional services performed by a physician during a maintenance dialysis episode if payments for his other professional services furnished to an individual who has end-stage renal disease are made on the basis specified in paragraph (3)(A) of this subsection, and (B) payments to or on behalf of such individuals for home dialysis supplies and equipment. The requirements prescribed by the Secretary under subparagraph (A) shall include requirements for a minimum utilization rate for covered procedures and for self-dialysis training programs.

"(2)(A) With respect to payments for dialysis services furnished by providers of services and renal dialysis facilities to individuals determined to have end-stage renal disease for which payments may be made under part B of this title, such payments (unless otherwise provided in this section) shall be equal to 80 percent of the amounts determined in accordance with subparagraph (B); and with respect to payments for services for which payments may be made under part A of this title, the amounts of such payments (which amounts shall not exceed, in respect to costs in procuring organs attributable to payments made to an organ procurement agency or histocompatibility laboratory, the costs incurred by that agency or laboratory) shall be determined in accordance with section 1861(v). Payments shall be made to a renal dialysis facility only if it agrees to accept such payments as payment in full for covered services, except for payment by the individual of 20 percent of the estimated amounts for such services calculated on the basis established by the Secretary under subparagraph (B) and the deductible amount imposed by section 1833(b).

42 USC 1395j.
42 USC 1395.
42 USC 1395x.
42 USC 1395l.

"(B) The Secretary shall prescribe in regulations any methods and procedures to (i) determine the costs incurred by providers of services and renal dialysis facilities in furnishing covered services to individuals determined to have end-stage renal disease, and (ii) determine, on a cost-related basis or other economical and equitable basis (including any basis authorized under section 1861(v)), the amounts of payments to be made for part B services furnished by such providers and facilities to such individuals. Such regulations shall provide for the implementation of appropriate incentives for encouraging more efficient and effective delivery of services (consistent with quality care), and shall include, to the extent determined feasible by the Secretary, a system for classifying comparable providers and facilities, and prospectively set rates or target rates with arrangements for sharing such reductions in costs as may be attributable to more efficient and effective delivery of services.

Regulations.

"(C) Such regulations, in the case of services furnished by proprietary providers and facilities may include, if the Secretary finds it feasible and appropriate, provision for recognition of a reasonable rate of return on equity capital, providing such rate of return does not exceed the rate of return stipulated in section 1861(v)(1)(B).

"(D) For purposes of section 1878, a renal dialysis facility shall be treated as a provider of services.

42 USC 1395oo.

"(3) With respect to payments for physicians' services furnished to individuals determined to have end-stage renal disease, the Secretary shall pay 80 percent of the amounts calculated for such services—

"(A) on a reasonable charge basis (but may, in such case, make payment on the basis of the prevailing charges of other physicians for comparable services) except that payment may not be made under this subparagraph for routine services furnished during a maintenance dialysis episode, or

"(B) on a comprehensive monthly fee or other basis for an aggregate of services provided over a period of time (as defined in regulations).

Agreements.

"(4) Pursuant to agreements with approved providers of services and renal dialysis facilities, the Secretary may make payments to such providers and facilities for the cost of home dialysis supplies and equipment and self-care home dialysis support services furnished to patients whose self-care home dialysis is under the direct supervision of such provider or facility, on the basis of a target reimbursement rate (as defined in paragraph (6)).

"(5) An agreement under paragraph (4) shall require, in accordance with regulations prescribed by the Secretary, that the provider or facility will—

"(A) assume full responsibility for directly obtaining or arranging for the provision of—

"(i) such medically necessary dialysis equipment as is prescribed by the attending physician;

"(ii) dialysis equipment maintenance and repair services;

"(iii) the purchase and delivery of all necessary medical supplies; and

"(iv) where necessary, the services of trained home dialysis aides;

Records.

"(B) perform all such administrative functions and maintain such information and records as the Secretary may require to verify the transactions and arrangements described in subparagraph (A);

"(C) submit such cost reports, data, and information as the Secretary may require with respect to the costs incurred for equipment, supplies, and services furnished to the facility's home dialysis patient population; and

"(D) provide for full access for the Secretary to all such records, data, and information as he may require to perform his functions under this section.

Target reimbursement rate.

"(6) The Secretary shall establish, for each calendar year, commencing with January 1, 1979, a target reimbursement rate for home dialysis which shall be adjusted for regional variations in the cost of providing home dialysis. In establishing such a rate, the Secretary shall include—

"(A) the Secretary's estimate of the cost of providing medically necessary home dialysis supplies and equipment;

"(B) an allowance, in an amount determined by the Secretary, to cover the cost of providing personnel to aid in home dialysis; and

"(C) an allowance, in an amount determined by the Secretary, to cover administrative costs and to provide an incentive for the efficient delivery of home dialysis;

but in no event shall such target rate exceed 70 percent of the national average payment, adjusted for regional variations, for maintenance dialysis services furnished in approved providers and facilities during the preceding fiscal year. Any such target rate so established shall be utilized, without renegotiation of the rate, throughout the calendar year for which it is established. During the last quarter of each calendar year, the Secretary shall establish a home dialysis target reimbursement rate for the next calendar year based on the most recent data available to the Secretary at the time. In establishing any rate under this paragraph, the Secretary may utilize a competitive-bid procedure, a prenegotiated rate procedure, or any other procedur which the Secretary determines is appropriate and feasible in order to carry out this paragraph in an effective and efficient manner.

Definitions.

"(7) For purposes of this title, the term 'home dialysis supplies and equipment' means medically necessary supplies and equipment (including supportive equipment) required by an individual suffering from end-stage renal disease in connection with renal dialysis carried out in his home (as defined in regulations), including obtaining, installing, and maintaining such equipment.

"(8) For purposes of this title, the term 'self-care home dialysis support services', to the extent permitted in regulation, means—

"(A) periodic monitoring of the patient's home adaptation, including visits by qualified provider or facility personnel (as defined in regulations), so long as this is done in accordance with a plan prepared and periodically reviewed by a professional team (as defined in regulations) including the individual's physician;

"(B) installation and maintenance of dialysis equipment;

"(C) testing and appropriate treatment of the water; and

"(D) such additional supportive services as the Secretary finds appropriate and desirable.

"(9) For purposes of this title, the term 'self-care dialysis unit' means a renal dialysis facility or a distinct part of such facility or of a provider of services, which has been approved by the Secretary to make self-dialysis services, as defined by the Secretary in regulations, available to individuals who have been trained for self-dialysis. A self-care dialysis unit must, at a minimum, furnish the services, equipment and supplies needed for self-care dialysis, have patient-staff ratios which are appropriate to self-dialysis (allowing for such appropriate lesser degree of ongoing medical supervision and assistance of ancillary personnel than is required for full care maintenance dialysis), and meet such other requirements as the Secretary may prescribe with respect to the quality and cost-effectiveness of services.

Network organizations.

"(c)(1)(A) For the purpose of assuring effective and efficient administration of the benefits provided under this section, the Secretary shall establish, in accordance with such criteria as he finds appropriate, renal disease network areas, such network organizations (including a coordinating council, an executive committee of such council, and a medical review board, for each network area) as he finds necessary to accomplish such purpose, and a national end stage renal disease medical information system. The Secretary may by regulations provide for such coordination of network planning and quality assurance activities and such exchange of data and information among agencies with responsibilities for health planning and quality assurance activities under Federal law as is consistent with the economical and efficient administration of this section and with the responsibilities established for network organizations under this section.

Regulations.

"(B) At least one patient representative shall serve as a member of each coordinating council and executive committee.

Regulations.

"(C) The Secretary shall, in regulations, prescribe requirements with respect to membership in network organizations by individuals (and the relatives of such individuals) (i) who have an ownership or control interest in a facility or provider which furnishes services referred to in section 1861(s)(2)(F), or (ii) who have received remuneration from any such facility or provider in excess of such amounts as constitute reasonable compensation for services (including time and effort relative to the provision of professional medical services) or goods supplied to such facility or provider; and such requirements shall provide for the definition, disclosure, and, to the maximum

42 USC 1395x.

Conflicts of interest.

extent consistent with effective administration, prevention of potential or actual financial or professional conflicts of interest with respect to decisions concerning the appropriateness, nature, or site of patient care.

"(2) The network organizations of each network shall be responsible, in addition to such other duties and functions as may be prescribed by the Secretary, for—

"(A) encouraging, consistent with sound medical practice, the use of those treatment settings most compatible with the successful rehabilitation of the patient;

Criteria and standards.

"(B) developing criteria and standards relating to the quality and appropriateness of patient care; and network goals with respect to the placement of patients in self-care settings and undergoing or preparing for transplantation;

"(C) evaluating the procedure by which facilities and providers in the network assess the appropriateness of patients for proposed treatment modalities;

"(D) identifying facilities and providers that are not cooperating toward meeting network goals and assisting such facilities and providers in developing appropriate plans for correction; and

Annual report to Secretary of Health, Education, and Welfare.

"(E) submitting an annual report to the Secretary on July 1 of each year which shall include a full statement of the network's goals, data on the network's performance in meeting its goals (including data on the comparative performance of facilities and providers with respect to the identification and placement of suitable candidates in self-care settings and transplantation), identification of those facilities that have consistently failed to cooperate with network goals, and recommendations with respect to the need for additional or alternative services or facilities in the network in order to meet the network goals, including self-dialysis training, transplantation, and organ procurement facilities.

"(3) Where the Secretary determines, on the basis of the data contained in the network's annual report and such other relevant data as may be available to him, that a facility or provider has consistently failed to cooperate with network plans and goals, he may terminate or withhold certification of such facility or provider (for purposes of payment for services furnished to individuals with end stage renal disease) until he determines that such provider or facility is making reasonable and appropriate efforts to cooperate with the network's plans and goals.

"(4) The Secretary shall, in determining whether to certify additional facilities or expansion of existing facilities within a network, take into account the network's goals and performance as reflected in the network's annual report.

Guidelines.

"(5) The Secretary, after consultation with appropriate professional and planning organizations, shall provide such guidelines with respect to the planning and delivery of renal disease services as are necessary to assist network organizations in their development of their respective networks' goals to promote the optimum use of self-dialysis and transplantation by suitable candidates for such modalities.

"(6) It is the intent of the Congress that the maximum practical number of patients who are medically, socially, and psychologically suitable candidates for home dialysis or transplantation should be so treated. The Secretary shall consult with appropriate professional and network organizations and consider available evidence relating to developments in research, treatment methods, and technology for home dialysis and transplantation. The Secretary shall periodically submit to the Congress such legislative recommendations as the Secretary finds

Report to Congress.

warranted on the basis of such consultation and evidence to further the national objective of maximizing the use of home dialysis and transplantation consistent with good medical practice.

42 USC 426.

42 USC 1395, 1395j.

Regulations.

"(d) Notwithstanding any provision to the contrary in section 226 any individual who donates a kidney for transplant surgery shall be entitled to benefits under parts A and B of this title with respect to such donation. Reimbursement for the reasonable expenses incurred by such an individual with respect to a kidney donation shall be made (without regard to the deductible, premium, and coinsurance provisions of this title), in such manner as may be prescribed by the Secretary in regulations, for all reasonable preparatory, operation, and postoperation recovery expenses associated with such donation, including but not limited to the expenses for which payment could be made if he were an eligible individual for purposes of parts A and B of this title without regard to this subsection. Payments for postoperation recovery expenses shall be limited to the actual period of recovery.

Agreements.

"(e)(1) Notwithstanding any other provision of this title, the Secretary may, pursuant to agreements with approved providers of services and renal dialysis facilities, reimburse such providers and facilities (without regard to the deductible and coinsurance provisions of this title) for the reasonable cost of the purchase, installation, maintenance and reconditioning for subsequent use of artificial kidney and automated dialysis peritoneal machines (including supportive equipment) which are to be used exclusively by entitled individuals dialyzing at home.

"(2) An agreement under this subsection shall require that the provider or facility will—

"(A) make the equipment available for use only by entitled individuals dialyzing at home;

"(B) recondition the equipment, as needed, for reuse by such individuals throughout the useful life of the equipment, including modification of the equipment consistent with advances in research and technology;

"(C) provide for full access for the Secretary to all records and information relating to the purchase, maintenance, and use of the equipment; and

Reports.

"(D) submit such reports, data, and information as the Secretary may require with respect to the cost, management, and use of the equipment.

"Supportive equipment."

"(3) For purposes of this section, the term 'supportive equipment' includes blood pumps, heparin pumps, bubble detectors, other alarm systems, and such other items as the Secretary may determine are medically necessary.

Experiments and pilot projects.

"(f)(1) The Secretary shall initiate and carry out, at selected locations in the United States, pilot projects under which financial assistance in the purchase of new or used durable medical equipment for renal dialysis is provided to individuals suffering from end stage renal disease at the time home dialysis is begun, with provision for a trial period to assure successful adaptation to home dialysis before the actual purchase of such equipment.

"(2) The Secretary shall conduct experiments to evaluate methods for reducing the costs of the end stage renal disease program. Such experiments shall include (without being limited to) reimbursement for nurses and dialysis technicians to assist with home dialysis, and reimbursement to family members assisting with home dialysis.

"(3) The Secretary shall conduct experiments to evaluate methods of dietary control for reducing the costs of the end stage renal disease program, including (without being limited to) the use of proteincontrolled products to delay the necessity for, or reduce the frequency of, dialysis in the treatment of end stage renal disease.

Studies.

"(4) The Secretary shall conduct a comprehensive study of methods for increasing public participation in kidney donation and other organ donation programs.

"(5) The Secretary shall conduct a full and complete study of the reimbursement of physicians for services furnished to patients with end stage renal disease under this title, giving particular attention to the range of payments to physicians for such services, the average amounts of such payments, and the number of hours devoted to furnishing such services to patients at home, in renal disease facilities, in hospitals, and elsewhere.

"(6) The Secretary shall conduct a study of the number of patients with end stage renal disease who are not eligible for benefits with respect to such disease under this title (by reason of this section or otherwise), and of the economic impact of such noneligibility of such individuals. Such study shall include consideration of mechanisms whereby governmental and other health plans might be instituted or modified to permit the purchase of actuarially sound coverage for the costs of end stage renal disease.

"(7) The Secretary shall conduct a study of the medical appropriateness and safety of cleaning and reusing dialysis filters by home dialysis patients. In such cases in which the Secretary determines that such home cleaning and reuse of filters is a medically sound procedure, the Secretary shall conduct experiments to evaluate such home cleaning and reuse as a method of reducing the costs of the end stage renal disease program.

Reports to Congress.

"(8) The Secretary shall submit to the Congress no later than October 1, 1979, a full report on the experiments conducted under paragraphs (1), (2), (3), and (7), and the studies under paragraphs (4), (5), (6), and (7). Such report shall include any recommendations for legislative changes which the Secretary finds necessary or desirable as a result of such experiments and studies.

"(g) The Secretary shall submit to the Congress on April 1, 1979, and April 1 of each year thereafter a report on the end stage renal disease program, including but not limited to—

"(1) the number of patients, nationally and by renal disease network, on dialysis (self-dialysis or otherwise) at home and in facilities;

"(2) the number of new patients entering dialysis at home and in facilities during the year;

"(3) the number of facilities providing dialysis and the utilization rates of those facilities;

"(4) the number of kidney transplants, by source of donor organ;

"(5) the number of patients awaiting organs for transplant;

"(6) the number of transplant failures;

"(7) the range of costs of kidney acquisitions, by type of facility and by region;

"(8) the number of facilities providing transplants and the number of transplants performed per facility;

"(9) patient mortality and morbidity rates;

"(10) the average annual cost of hospitalization for ancillary problems in dialysis and transplant patients, and drug costs for transplant patients;

"(11) medicare payment rates for dialysis, transplant procedures, and physician services, along with any changes in such rates during the year and the reasons for those changes;

"(12) the results of cost-saving experiments;

"(13) the results of basic kidney disease research conducted by the Federal Government, private institutions, and foreign governments;

"(14) information on the activities of medical review boards and other networks organizations; and

"(15) estimated program costs over the next five years.".

Hospital insurance benefits.
42 USC 426.

SEC. 3. (a) Section 226(a) of the Social Security Act is amended—

(1) by striking out "specified in subparagraph (B)" and inserting in lieu thereof "specified in paragraph (1)"; and

(2) by striking out "specified in subparagraphs (A) and (B)" and inserting in lieu thereof "specified in paragraphs (1) and (2)".

(b) Paragraphs (2) and (3) of section 226(e) of such Act (as redesignated by subsection (b)(2) of the first section of this Act) are each amended by striking out "subsection b" and inserting in lieu thereof "subsection (b)".

Insurance program.
42 USC 1395c.

SEC. 4. (a) Section 1811 of the Social Security Act is amended—

(1) by striking out "section 226" and inserting in lieu thereof "sections 226 and 226A";

(2) by striking out "and" at the end of clause (1), and inserting in lieu thereof a comma; and

(3) by inserting immediately before the period the following: ", and (3) certain individuals who do not meet the conditions specified in either clause (1) or (2) but who are medically determined to have end stage renal disease".

Payment of benefits.
42 USC 1395*l*.

(b) Section 1833(a)(1) of such Act is amended—

(1) by striking out "and" at the end of clause (C), and

(2) by adding the following after "section)," in clause (D): "and (E) with respect to services furnished to individuals who have been determined to have end stage renal disease, the amounts paid shall be determined subject to the provisions of section 1881, and".

Ante, p. 308.
42 USC 1395*l*.

(c) Section 1833(a)(2) of such Act is amended by inserting "(unless otherwise specified in section 1881)" after "other services".

42 USC 1395x.

(d) Section 1861(s)(2) of such Act is amended—

(1) by striking out "and" at the end of clause (D);

(2) by inserting "and" at the end of clause (E); and

(3) by adding the following new clause after clause (E):

"(F) home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies;".

Agreements, service providers.
42 USC 1395cc.

(e) The first sentence of section 1866(a)(2)(A) of such Act is amended by inserting the following before the period: "(but in the case of items and services furnished to individuals with end-stage renal disease, an amount equal to 20 percent of the estimated amounts for such items and services calculated on the basis established by the Secretary)".

42 USC 1395f.

(f) Section 1814(b)(1) of such Act is amended by inserting "and as further limited by section 1881(b)(2)(B)" after "1861(v)".

42 USC 1395i.
42 USC 1395t.
42 USC 1395mm.

SEC. 5. The third sentence of section 1817(b) of the Social Security Act, and the third sentence of section 1841(b) of such Act, and section 1876(b)(2)(B) of such Act, are each amended by striking out "Commissioner of Social Security" and inserting in lieu thereof "Administrator of the Health Care Financing Administration".

Effective date.
42 USC 426 note.

SEC. 6. The amendments made by the preceding sections of this Act shall become effective with respect to services, supplies, and equipment furnished after the third calendar month which begins after the date of the enactment of this Act, except that those amendments providing for the implementation of an incentive reimbursement system for dialysis services furnished in facilities and providers shall become effective with respect to a facility's or provider's first accounting period which begins after the last day of the twelfth month following the month of the enactment of this Act, and those amendments providing for reimbursement rates for home dialysis shall become effective on April 1, 1979.

42 USC 1395x.

SEC. 7. Section 15(d) of Public Law 93-233 (as amended by section 7(c) of Public Law 93-368 and the first section of Public Law 94-368) is amended by striking out "October 1, 1977" and inserting in lieu thereof "October 1, 1978".

42 USC 1396d.

SEC. 8. (a) The first sentence of section 1905(c) of the Social Security Act is amended—

(1) by striking "and (3)" and inserting in lieu thereof "(3)"; and

42 USC 1395x.

(2) by striking out the period at the end thereof and inserting in lieu thereof the following ", and (4) meets the requirements of section 1861(j)(14) with respect to protection of patients' personal funds.".

(b) The fourth sentence of section 1905(c) of such Act is amended by striking out "clauses (2) and (3)" and inserting in lieu thereof "clauses (2), (3), and (4)".

Regulations.
42 USC 1396d note.

42 USC 1396.

(c) The Secretary of Health, Education, and Welfare shall, by regulation, define those costs which may be charged to the personal funds of patients in intermediate care facilities who are individuals receiving medical assistance under a State plan approved under the provisions of title XIX of the Social Security Act, and those costs which are to be included in the reasonable cost or reasonable charge for intermediate care facility services as determined under the provisions of such title.

Effective date.
42 USC 1396d note.

(d)(1) The amendments made by subsections (a) and (b) shall become effective on July 1, 1978.

Regulations.
42 USC 1396d note.

(2) The Secretary of Health, Education, and Welfare shall issue the regulations required under subsection (c) within 90 days after the date of enactment of this Act but not later than July 1, 1978.

42 USC 1396b note.

(e) Section 20(c)(2) of the Medicare-Medicaid Anti-Fraud and Abuse Amendments (Public Law 95-142) is amended by striking out "section 1905(g)" and inserting in lieu thereof "section 1903(g)".

Approved June 13, 1978.

LEGISLATIVE HISTORY:

HOUSE REPORT No. 95-549 (Comm. on Ways and Means).
SENATE REPORT No. 95-714 (Comm. on Finance).
CONGRESSIONAL RECORD:
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May 1, House concurred in Senate amendment with an amendment.
May 24, Senate concurred in House amendment.
WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS:
Vol. 14, No. 24 (1978): June 13, Presidential statement.

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95TH CONGRESS 1st Session } HOUSE OF REPRESENTATIVES { REPORT No. 95-549

END STAGE RENAL DISEASE PROGRAM

REPORT

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ON

H.R. 8423

JULY 29, 1977.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

U.S. GOVERNMENT PRINTING OFFICE
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95TH CONGRESS } HOUSE OF REPRESENTATIVES { REPORT
1st Session } { No. 95–549

END STAGE RENAL DISEASE PROGRAM

JULY 29, 1977.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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Mr. ULLMAN, from the Committee on Ways and Means, submitted the following

REPORT

[To accompany H.R. 8423]

The Committee on Ways and Means, to whom was referred the bill (H.R. 8423) to amend titles II and XVIII of the Social Security Act to make improvements in the end stage renal disease program presently authorized under section 226 of that act, having considered the same, report favorably thereon with amendments and recommend that the bill as amended do pass.

The amendments (stated in terms of the page and line numbers of the introduced bill) are as follows:

Page 3, line 5, strike out "subsection" and insert in lieu thereof "section".

Page 5, line 10, strike out "(c)" and insert in lieu thereof "(d)".

Page 5, line 25, insert after "for" the following: institutional dialysis, services, transplantation services,".

Page 6, line 1, strike out "facility" and insert in lieu thereof "facility,".

Page 6, line 8, after "for" insert "dialysis".

Page 10, line 11, strike out "rate" and insert in lieu thereof "payment".

Page 10, line 14, after "such" insert "target".

Page 10, line 24, strike out "manner.'" and insert in lieu thereof "manner."

Page 11, line 2, after "equipment" insert "(including supportive equipment)".

Page 11, line 5, strike out "the necessary dialysis" and insert in lieu thereof "such".

Page 11, line 6, strike out the comma and all that follows down through "home" on line 9.

Page 12, line 13, strike out "services.'" and insert in lieu thereof "services."

Page 14, line 20, strike out "shall" and insert in lieu thereof "may".

Page 15, line 5, strike out "cooperating" and insert in lieu thereof "making reasonable and appropriate efforts to cooperate".

Page 15, beginning in line 11, strike out ", be transplanted, or be active candidates for transplantation" and insert in lieu thereof "or be transplanted".

Page 18, line 9, strike out "subsection," and insert in lieu thereof "section,".

Page 21, line 12, strike out "screens" and insert in lieu thereof "rates".

Page 21, line 14, strike out "screens" and insert in lieu thereof "rates".

Page 23, after line 19, insert the following new section:

> SEC. 5. The third sentence of section 1817(b) of the Social Security Act, and the third sentence of section 1841(b) of such Act, are each amended by striking out "Commissioner of Social Security" and inserting in lieu thereof "Administrator of the Health Care Financing Administration".

Page 23, line 20, strike out "5." and insert in lieu thereof "6.".

Page 24, line 3, after "facility's" insert "or provider's".

Amend the title so as to read:

> A bill to amend titles II and XVIII of the Social Security Act to make improvements in the end stage renal disease program presently authorized under section 226 of that Act, and for other purposes.

I. PURPOSE AND BACKGROUND OF THE BILL

During the past several years your committee has undertaken a number of studies and public hearings in order to assess the operation and effectiveness of the medicare end-stage renal disease program. The results of these efforts indicate that the program has been generally successful in meeting the needs of renal disease patients for insurance protection against the often catastrophic costs of dialysis and transplantation. However, at the same time, it has become clear that the program is plagued by a number of serious problems which threaten to undermine its continuing stability and effectiveness. Your committee believes that it is essential to promptly address and resolve these critical problems.

Your committee is concerned about the high and steadily rising cost of the program and the burden it can place on the medicare trust funds unless steps are taken to put it on a more cost-effective basis. The committee believes that there are several areas of potential cost savings, including the increased use of self-dialysis settings and tranplantation, and the ue of incentive reimbursement methods to encourage economies in the delivery of services.

Fortunately, this is a program where the introduction of appropriate incentives to encourage the use of lower cost treatment modalities is wholly compatible with the best interests of renal disease patients and with sound medical practice. The patient who successfully undergoes transplantation can return to a relatively normal and stable life. The patient who can successfully manage self-dialysis either in his own home or in a self-care dialysis unit of a facility regains a significant measure of control over his own care and escapes from what might otherwise be a permanently dependent relationship.

And in both types of cases, program savings over the long run can be substantial. Similarly, the use of an incentive reimbursement method in this program can produce savings through more cost-effective, efficient delivery of needed services.

On April 25 a hearing was held by your committee's Subcommittee on Health on proposed legislation to amend the renal disease program. (Several prior hearings on the administration of the program were held by the committee's Subcommittee on Oversight.) The Subcommittee on Health considered specific legislation (H.R. 3112) in executive session on July 19, reporting a clean bill (H.R. 8423) to the full committee, and the full Committee on Ways and Means considered H.R. 8423 and ordered it reported on July 25, 1977.

Your committee fully recommends this legislation in the belief that it will enhance the protection afforded by the program while at the same time assuring that the program's cost is maintained at a reasonable level.

II. Summary of the Bill

As reported, the provisions of H.R. 8423, the medicare renal disease program amendments, are designed to accomplish five objectives: Provide incentives for the use of lower cost, medically appropriate self-dialysis (particularly home dialysis), as an alternative to high-cost institutional dialysis; eliminate current program disincentives to the use of transplantation; provide for the implementation of incentive reimbursement methods to assure more cost-effective delivery of services to patients dialyzing in institutions and at home; develop a long-range national objective, on the basis of the continuing review and judgment of professional peer review organizations, with respect to the most effective use of resources for treating renal disease; and provide for studies of alternative ways to improve the program and for regular reporting to the Congress on the renal disease program. The summary presented below briefly outlines the principal features of the bill as reported under the general headings referred to above.

INCENTIVES FOR USE OF SELF-DIALYSIS

Your committee's bill includes several provisions designed to provide incentives for more extensive use of lower cost, medically appropriate self-care dialysis settings. Although the cost of treatment in self-dialysis settings is considerably less for the program than facility dialysis, there has been a steady decline in the percentage of patients on home dialysis. Experience indicates that one of the more important reasons for this decline is the existence of financial disincentives, resulting from the benefit structure of the medicare program, for patients to undertake self-dialysis. The bill, therefore, modifies present law to eliminate these disincentives by:

1. Providing for the waiver of the 3-month waiting period under present law for a beneficiary who enters a self-care training program prior to the end of the third month after the month his regular course of dialysis begins;

2. Providing for the coverage of disposable supplies (such as syringes, needles, and sterile drapes) required for the effective performance of home dialysis;

3. Providing coverage for periodic supportive services, including emergency visits and servicing of dialysis equipment, furnished by facilities to individuals dialyzing at home;

4. Providing coverage for services of a self-care dialysis unit maintained by a renal dialysis facility; and

5. Authorizing full reimbursement to facilities for dialysis equipment purchased by facilities for the exclusive use of patients dialyzing at home.

ELIMINATE DISINCENTIVES TO TRANSPLANTATION

Your committee's bill includes several provisions designed to eliminate those disincentives to transplantation related to limitations in the entitlement requirements of present law which expose transplant candidates to significant financial risk. Thus, the bill provides for:

1. Coverage for a transplant patient beginning with the month he is hospitalized, without regard to the waiting period of present law, if transplant surgery takes place within that month or the following 2 months;

2. Extension of the period of medicare coverage for patients who undergo transplantation from 12 months (under present law) to 36 months;

3. Immediate resumption of coverage, without a waiting period, whenever a transplant fails; and

4. Coverage for expenses incurred by live kidney donors, including the period of the donor's recovery.

REIMBURSEMENT METHODS

In order to assure more cost-effective reimbursement for dialysis services furnished to renal disease patients, your committee's bill provides for the implementation of incentive reimbursement methods for services furnished by renal dialysis facilities to patients dialyzing in the facility or at home. Under the bill, such methods may include prospectively set rates, a system for classifying comparable facilities, the use of target rates (adjusted for regional differences) with provision for sharing savings attributable to efficient and effective delivery of services, and other incentives to efficient performance. (The Secretary may use competitive-bid procedures, prenegotiated rate procedures or such other procedures as he finds feasible and appropriate in establishing the home dialysis target rates.)

Your committee's bill also clarifies present law concerning the alternative reimbursement methods available to physicians with respect to services provided in connection with routine maintenance dialysis episodes.

PEER REVIEW OF SELF-DIALYSIS AND TRANSPLANTATION

Your committee's bill assigns responsibility to renal disease network peer review organizations for establishing goals for the identification and placement of suitable candidates in self-care settings and transplantation, and for assessing the performance of facilities in meeting these goals. The bill also establishes a long-range national objective, utilizing the experience and recommendations of professional peer review organizations, with respect to the use of self-dialysis settings and transplantation by suitable candidates.

STUDIES, REPORTS, AND ADMINISTRATION

Your committee's bill requires the Secretary to conduct experiments and studies on ways to reduce program costs, without impairing the quality of care, including studies relating to the reuse of dialysis filters and the use of dietary controls, to increase public participation in organ donation programs, and to assess alternative ways of financing renal disease services. The bill also requires the Secretary to submit an annual report to the Congress on the cost and operation of the program, and on developments with respect to basic and applied research in the field of renal disease. Under the bill, the Secretary is authorized to develop appropriate administrative structures and arrangements to carry out his responsibilities.

MINOR AND TECHNICAL AMENDMENTS

Your committee's bill amends the entitlement provisions of present law to clarify the intent that individuals with end-stage renal disease are deemed to satisfy the requirements relating to disability beneficiaries. The bill also provides that the Administrator of the Health Care Financing Administration shall serve, in lieu of the Commissioner of Social Security, as the Secretary of the Board of Trustees of the Hospital Insurance and Supplementary Medical Insurance Trust Funds.

III. GENERAL STATEMENT

EXPLANATION, JUSTIFICATION, AND COMPARISON WITH PRESENT LAW

A. Incentives for use of self-dialysis

Your committee's bill includes several provisions designed to provide incentives for more extensive use of lower cost, medically appropriate self-care dialysis settings. Although dialysis can be performed in either the home or in an institutional setting, the choice of dialysis location has significant cost implications. The cost of home dialysis is considerably less than institutional dialysis. Studies indicate that the current annual cost of home dialysis ranges from $8,000 to $12,000 while the annual cost of institutional dialysis ranges from over $15,000 to $30,000. Thus, the cost of facility dialysis is generally twice the cost of home dialysis. Moreover, increased use of home dialysis creates the potential for significant reductions in the need for capital investment in facilities and personnel.

However, since 1972, the year in which the medicare renal disease program was enacted, there has been a steady decline in the percentage of patients on home dialysis. According to the National Dialysis Register, over 40 percent of the total patients on dialysis were dialyzing at home in 1972. By the beginning of 1975, the percentage on home dialysis had declined to 25 percent; and, according to data just released by the Department the decline has continued—as of calendar year 1976, according to this data, less than 10 percent of dialysis patients are on home dialysis. While various reasons for this decline have been offered (including changes in the patient population under treatment, professional disinterest in encouraging home dialysis, and increased access to institutional facilities), the evidence suggests that one of the major reasons is the existence of financial disincentives for patients to undertake self-care dialysis.

At the same time that the use of home dialysis has been declining, renal disease program costs have been rising at a significantly higher rate than forecast. Current estimates furnished by the Department indicate that renal disease program costs for fiscal year 1978 will be $0.9 billion and will increase substantially in subsequent years. The following table furnished to your committee by the Department illustrates the anticipated increases:

Estimate of annual benefits paid

Fiscal year:	*Benefits in billions*
1980	$1.3
1982	1.9
1987	3.6
1992	6.3

Moreover, the patient population for which these costs would be incurred is a relatively small one. As of March 1977, about 36,000 renal disease patients were covered by the program. The rate of increase in enrolled beneficiaries is about 4 percent per year and is expected to decline to about one-half of 1 percent by 1985. Thus, it is estimated that the program will have an enrolled renal population of approximately 60,000 by 1986 and a stable population of about 75,000 by the year 2000.

While it is true that the high cost of the program is, in part, a reflection of the costly technology required for treatment, and the need in most cases for lifetime care, it is generally agreed that rising program costs are also a reflection of disincentives in the program to the use of lower cost self-dialysis procedures and settings. Your committee believes that appropriate incentives for more cost-effective use of self-care dialysis settings can help significantly to contain rising program costs without impairing the quality or availability of needed services.

WAIVER OF 3-MONTH WAITING PERIOD FOR SELF-CARE TRAINING

Your committee's bill would provide for waiver of the waiting period under present law in the case of an individual who participates in a self-care training program prior to the end of the third month after the month he initiates a regular course of dialysis.

Under present law, a renal disease patient under age 65 becomes entitled to medicare benefits beginning with the first day of the third month after the month a course of dialysis is initiated. This 3-month waiting period discourages prompt entry into a self-care training program since the beneficiary would also have to bear the additional cost of this training out-of-pocket. Moreover, once adjusted to facility dialysis, patients are often reluctant to make the change to self-care dialysis.

Your committee believes that this provision will help to overcome the reluctance on the part of many beneficiaries to undertake self-dialysis training. However, it is expected that the Secretary will take appropriate steps to assure that it is understood the waiver is intended for those individuals who can be reasonably expected to complete the training program and, on completion, to enter into a self-dialysis setting.

Coverage of supplies necessary to perform home dialysis

Your committee's bill provides coverage for all supplies, including disposable supplies, required for the effective performance of home dialysis.

Under present law, home dialysis results in a substantially larger out-of-pocket expense to the patient than facility dialysis. This is so because under the existing medicare benefit structure certain expenses that are covered in an institutional setting are not covered at the patient's home. Where dialysis is done in a facility, for example, disposable items and supplies which are necessary for the performance of dialysis (such as syringes, alcohol wipes, sterile drapes, needles, topical anesthesias, and rubber gloves) and various types of supportive equipment are covered. When dialysis is performed at home, these items—which represent as much as 15 percent of costs incurred by beneficiaries who self-dialyze at home—are not covered and the patient must pay for them out of his personal funds.

Although it has been argued that coverage of disposable items and supplies for renal patients would represent a departure from traditional medicare coverage provisions, there is a precedent for such coverage in the current provision of medicare law under which all colostomy supplies, including disposables, are covered. The reason for extending coverage in both of these cases is the unique nature of the medical procedures involved and the indispensable and continuing need for the supplies in the effective management of the patient's care. Moreover, your committee believes that coverage of such items and supplies in the case of renal disease patients would eliminate a significant disincentive to home dialysis.

COVERAGE OF HOME DIALYSIS SUPPORT SERVICES

Your committee's bill provides coverage for periodic support services, to the extent permitted in regulations, furnished by a renal dialysis facility or hospital to an individual dialyzing at home. Such support services could include periodic monitoring of the patient's adaptation to self-dialysis, emergency visits where necessary, help in the installation and maintenance of dialysis equipment and any additional supportive services the Secretary determines will be useful in helping patients to remain on home dialysis.

Under present law, mechanisms do not exist to either monitor actual home dialysis performance or provide backup professional and maintenance assistance in the home. If trained technical personnel (functioning under physician supervision) were permitted to periodically observe the patient's management of his dialysis, assist with difficult access situations, or occasionally function as a dialysis assistant, incentives to continued use of home dialysis would result by precluding the need for unnecessary inpatient treatment or backup institutional dialysis. Moreover, help in maintaining equipment is generally regarded as a vital element in the overall effort to assist those beneficiaries who might otherwise become discouraged by the problems and expense involved in servicing their own equipment to remain on home dialysis.

COVERAGE FOR SERVICES OF A SELF-CARE DIALYSIS UNIT

Your committee's bill provides for reimbursement of facilities for the maintenance of a self-dialysis unit in which a paitent can manage his own treatment with a lesser degree of ongoing medical supervision and assistance of ancillary personnel than is required for full care maintenance dialysis. Under the bill, a self-dialysis unit must, at a minimum, furnish the services, equipment, and supplies needed for self-care dialysis, have patient-staff ratios which are appropriate to self-dialysis (allowing for such appropriate lesser degree of ongoing medical supervision and assistance) and meet such other requirements as the Secretary may prescribe with respect to the quality and cost-effectiveness of services.

Your committee recognizes that many patients who are otherwise highly motivated to undertake self-dialysis are unable to do so because of physical or social circumstances in the home environment. For such patients the only alternative usually available to them at present is full care maintenance dialysis in an institutional setting. Your commitee has, therefore, included in the bill a provision which encourages the use of self-care stations in renal dialysis facilities. Under the bill, the Secretary would be authorized to define what constitutes self-care dialysis outside the home setting and to identify the institutional settings in which it can be appropriately performed. In defining appropriate self-care dialysis settings, your committee expects the Secretary to identify those factors which differentiate full-care dialysis from self-care dialysis—for example, staff-to-patient ratios. In addition, the definition of self-care dialysis should specify the types of support services the facility is required to provide as an integral part of self-care, as well as those services which are not required but which would be considered an acceptable part of self-care for reimbursement purposes.

Your committee does not intend that there be a proliferation of underutilized self-care units. Thus, your committee expects that the Secretary will apply minimum utilization requirements and will take appropriate steps to assure himself that a need exists for the unit before authorizing its reimbursement.

REIMBURSEMENT TO FACILITIES FOR REASONABLE COST OF DIALYSIS EQUIPMENT FOR HOME DIALYSIS PATIENTS

Your committee's bill authorizes the Secretary, pursuant to agreements with approved renal dialysis facilities, to reimburse such facilities for the full reasonable cost of the purchase, installation, maintenance and reconditioning for subsequent reuse of artificial kidney and automated dialysis peritoneal machines (including supporting equipment) which are reserved for the exclusive use of entitled renal disease patients dialyzing at home. In order to waive the coinsurance amount the Secretary would be required to assure by formal agreement that the provider or facility will: (a) Use the equipment only for home dialysis patients; (b) recondition the equipment, as needed, for reuse by other home dialysis patients; (c) provide full access for the Secretary to all records and information relating to the purchase, maintenance and use of the equipment; and (d) submit such reports as the Secretary may require with respect to the management and use of the equipment. Supporting equipment would include blood pumps, heparin pumps, bubble detectors, other alarm systems and such other items as the Secretary may determine are medically necessary.

Under present law, medicare can provide for either purchase or rental of durable medical equipment. In cases of purchases of more than $50, medicare reimbursement is generally made in monthly installments equivalent to the amounts that would have been paid had the equipment been rented. The payments are continued for as long as the equipment is needed or, in the case of purchase, until the total of the monthly installments equals 80 percent of the purchase price. The patient is, of course, expected to pay for 20 percent of the cost of the equipment.

In the case of a $5,000 dialysis machine, this provision makes patient purchase nearly impossible. In this example, the patient would be faced with financing the total cost of the machine and being reimbursed by medicare for $4,000 of the cost in small monthly payments. The result is that few home dialysis patients purchase their own equipment. Instead, patients rent equipment. Some rental charges are now running more than $300 per month. In addition, maintenance charges by equipment companies appear to be significantly higher than the cost to facilities to repair their own equipment. Examples provided to your committee show that in many cases, within 1½ to 2 years, the patient and medicare will often pay in rent an amount equal to the total purchase price of the equipment. While many rental contracts provide for the servicing of the equipment and a lowering of the rent and/or an option to buy after several years, the fact remains that medicare rental payments are generally many times the purchase price of the equipment.

While it is difficult to estimate precisely the program saving that might be expected to result from direct purchase, data submitted to your committee indicate that annual savings, even assuming the present proportion of patients on home dialysis, could be as high as $3 million. Your committee wishes to emphasize, however, that such savings are attainable on the assumption that the equipment approved for purchase is neither extravagant nor excessive. It is expected, therefore, that the Secretary will develop appropriate criteria and procedures to assure that such equipment as is approved for purchase will be limited to equipment that is sufficient for the medical purposes required and that facilities exercise prudence and sound business practices in the purchase of such equipment.

But perhaps even more important than the direct dollar savings projected on these purchases would be the removal of this significant financial disincentive to home dialysis. Your committee believes that the larger savings that would accrue to the program from increased use of home dialysis warrant the use of an arrangement under which approved facilities purchase and maintain dialysis equipment exclusively for the use of patients dialyzing at home. Moreover, utilizing such arrangements with approved facilities will assure the most effective, continued use of this sophisticated technology throughout its useful life and a greater degree of professional supervision over the medical management of the patient's home care.

The cost of a kidney transplant now runs between $20,000 and $25,000. A successful patient would then incur costs of about $3,000 in the first year following transplantation for drugs and physician services, and between $1,000 and $2,000 a year thereafter. Slightly over 3,000 patients (about 10 percent of the rental patient population) attempted transplantation in 1976, and many nephrologists believe that with appropriate encouragement that figure could be significantly increased. Your committee believes that the elimination of these disincentives is essential to assure that patients have the opportunity to make this important medical choice unencumbered by financial considerations imposed by the coverage provisions of medicare.

COVERAGE BEGINNING WITH MONTH OF HOSPITALIZATION

Your committee's bill modifies present law by beginning coverage for a transplant patient with the month of hospitalization if the surgery takes place within the following 2 months, rather than the following 1 month as under present law. Transplantation is a two-step process: First, the removal of the diseased kidney; second, the implantation of a new kidney which, in some cases, may not take place for as long as 6 to 8 weeks after the first step. A 2-month provision would assure equitable coverage of all transplant patients.

POST-TRANSPLANT COVERAGE EXTENDED TO 36 MONTHS

Your committee's bill would extend the period of medicare coverage for patients who undergo transplantation from 12 to 36 months.

Under present law, medicare entitlement for a transplant patient terminates at the end of the 12th month following transplantation. However, a great many transplants have not stabilized or cannot be deemed successful after 12 months. As a result, many patients are either hospitalized or undergoing intensive out-patient treatment for rejection episodes during or shortly after the twelfth month, at the very time their medicare benefits are being terminated. Moreover, even successful transplant patients incur substantial medical costs directly related to the transplant for several years following the surgery, although the heaviest costs are incurred in the first three years. Your committee's bill would alleviate this problem by assuring a sufficient period of post-transplant coverage to preclude such devastating financial crises.

IMMEDIATE RESUMPTION OF COVERAGE WITHOUT A WAITING PERIOD IF TRANSPLANT FAILS

Under present law, a patient whose transplant fails after his entitlement ends is liable for the substantial costs associated both with the failure of the transplant and any dialysis required during the waiting period before medicare coverage resumes. Your committee's bill eliminates this disincentive by providing for the immediate resumption of medicare coverage whenever a transplant is rejected.

CLARIFY PRESENT LAW RELATING TO EXPENSES INCURRED BY KIDNEY DONORS

Your committee's bill clarifies the Secretary's authority under present law to provide reimbursement for the costs incurred in connection with kidney donations. Your committee believes that such a policy is essential both to assure a continued supply of live donor organs and to take into account, in the medicare reimbursement system, appropriate medical costs related to organ procurement (which cannot always be assigned to a particular beneficiary), including a donor's postoperative recovery costs.

C. Reimbursement Methods

When the Congress enacted the renal disease program in 1972, it did so in full recognition of the fact that substantial difficulties would be encountered in the development of equitable reimbursement policies. Little data was then available either on treatment costs or on prevailing charges. Moreover, there was a great variety of arrangements through which services in the relatively new field of renal dialysis were rendered. As a result, the Congress authorized the Secretary to develop and apply reimbursement policies and procedures on the basis of evolving experience. Based on this extensive program experience your committee believes that several changes that would result in more cost-effective reimbursement can be made both in the method for paying facilities for dialysis services rendered to patients dialyzing in the facility, and in the method by which payment is made for expenses incurred by patients dialyzing at home under the supervision of approved facilities. In addition, your committee believes that it is now appropriate to clarify present law relating to the alternative reimbursement methods available to physicians with respect to services provided in connection with routine maintenance dialysis episodes.

Clarify present law relating to alternative reimbursement methods for physicians' services

Your commitee's bill clarifies the Secretary's authority under present law to provide reimbursement for physicians' services in connection with routine maintenance dialysis in accordance with alternative reimbursement methods.

Under present program policies, physicians have a choice between two methods for receiving reimbursement for routine maintenance dialysis services. Under one method, the physician can bill the medicare program reasonable charges for all emergency services he furnishes during a maintenance dialysis episode; the physician looks to the facility for payment for his routine dialysis services and the facility is reimbursed for these payments by the program.

The second method, called "comprehensive reimbursement," provides for payment of a reasonable charge for all medical services furnished to a maintenance dialysis patient during a month, other than inpatient hospital services and services not related to the patient's renal problem that require extra visits. (Reasonable charges for these latter services may be billed separately.) About one-fourth of all nephrologists have elected this method of reimbursement.

Your committee believes that the use of these optional reimbursement methods is consistent with the congressional intent to develop reimbursement methods and procedures designed to address the unique circumstances involved in the provision of maintenance dialysis services.

INCENTIVE REIMBURSEMENT METHOD FOR SERVICES FURNISHED BY RENAL DIALYSIS FACILITIES TO PATIENTS DIALYZING IN THE FACILITY

Your committee's bill modifies present law to provide for the implementation of an incentive reimbursement system with respect to dialysis services furnished by facilities to patients dialyzing in the facility. Under the bill, the Secretary would be required to promulgate regulations providing (as part of the reimbursement system) for the implementation of appropriate incentives for encouraging more efficient and effective delivery of dialysis services, including (to the extent and in such combination as he determines feasible), the use of prospectively set rates, a system for classifying comparable facilities, target rates with arrangements for sharing such reductions in cost as may be attributable to more efficient and effective delivery of services, and such other incentives as he finds will encourage more cost-effective delivery consistent with quality care. The incentive reimbursement system, which may be established on a cost-related or other equitable and economically efficient basis, would become effective with respect to a facility's first accounting period occurring on or after October 1, 1978. The bill authorizes the Secretary to prescribe in regulations such methods and procedures as are necessary to determine costs incurred in furnishing renal dialysis services and to determine amounts payable in accordance with the incentive reimbursement system. Moreover, such regulations, in the case of services furnished by proprietary facilities may include, if the Secretary finds it feasible and appropriate, provision for recognition of a reasonable rate of return on equity capital, providing such rate of return does not exceed the rate currently provided for in the Social Security Act for other proprietary institutions participating in the medicare program.

In addition, the bill clarifies the Secretary's authority under present law to (a) require facilities reimbursed on a cost-related basis to agree not to charge beneficiaries more for covered services they provide than the applicable deductible and coinsurance amounts, and (b) to provide for reimbursement to hospitals for their costs attributable to payments made to an organ procurement agency or histocompatibility laboratory in amounts that may not exceed costs incurred by that agency or laboratory. The bill further provides that renal dialysis facilities reimbursed on a cost-related basis will have the same appeal rights hospitals and other providers of services now have under medicare when a disagreement results with respect to program reimbursement.

The two criticisms most often made of the present "reasonable charges" method for reimbursing renal dialysis facilities is that (1) it does not permit the program to effectively adjust payment limits as prices and circumstances vary or as now facilities come into operation; and (2) it allows facilities to receive reimbursement based on their own charges regardless of the relationship to cost. Although the congressional intent at the time of enactment was to provide for the development of a "charges related to reasonable cost" method, this intent was not sufficiently clarified in congressional reports, and efforts by the Secretary to obtain appropriate cost data from some facilities in accordance with this intent have been challenged. Your committee believes that in view of the rising cost of the program, provision needs to be made for a reimbursement method for renal dialysis facilities which permits the development of reasonable upper limits on program reimbursement and provides incentives to economize.

Your committee's bill addresses these problems directly by providing for the implementation of an incentive reimbursement method the design of which will encourage facilities to deliver services on a cost-effective basis. To an increasing degree, congressional attention has been focused on the need to develop prospective reimbursement methods and target rates to encourage more efficient management of health facilities and to stimulate better planning in the delivery of services. The method included in your committee's bill reflects this general philosophy; it provides for the use of prospectively set rates and for the use of arrangements under which efficiently managed facilities may share in the savings they produce.

Although the bill authorizes the use of various types of incentives for more efficient delivery of services, your committee recognizes that some testing and phasing-in of these incentives may be necessary. Thus, the bill authorizes the implementation of such incentives in such combination and in accordance with such timing as the Secretary finds administratively feasible, consistent with the intent to establish an incentive reimbursement system.

Consistent with the provision for cost-related reimbursement, the bill reaffirms the Secretary's authority to reimburse a facility for furnishing covered services under the program only if the facility accepts such payment as payment in full, except for applicable deductible and coinsurance amounts. The facility could, of course, charge the beneficiary or other third-party payers for noncovered services. Your committee expects that the Secretary will request renal dialysis facilities to furnish such reports and information concerning the costs of their operations and their compliance with such other requirements relating to program participation as are specified in the Social Security Act and regulations promulgated in accordance with it, including notification to the Secretary if a facility can no longer meet the conditions for participation as an approved supplier or if it contemplates the expansion or addition of services. These requirements will help assure the orderly expansion of facility treatment resources and prevent wasteful duplication of services by precluding expansion without the express approval of the Secretary. Your committee believes these requirements should help to restrain the cost escalation of the program by assuring maximum utilization of existing facilities, personnel, and equipment.

Your committee realizes that disputes may arise with respect to determinations of the costs incurred by renal dialysis facilities and the amounts payable under the program. The medicare intermediary appeals process should suffice to resolve disputes involving small amounts. Where the amounts in controversy are substantial—$10,000 or more for an individual facility, or $50,000 or more in the aggregate for a group of facilities—your committee has provided that renal dialysis facilities may appeal to the Provider Reimbursement Review Board.

Under present law, pretransplant services furnished by organ procurement agencies and histocompatibility laboratories are reimbursed as inpatient hospital services at the time of transplantation. This policy has been effective in providing coverage of pretransplant services; however, it has not provided the program with adequate fiscal controls. For example, when an organ procurement agency provides a kidney to a transplant hospital, it is billed to the hospital directly and the components of the charge are not subject to the review of the medicare intermediary as are other services provided directly by the hospital. In addition, a kidney may be handled by several agencies before it is delivered to the transplant hospital and each agency will add an amount to the charge which is not necessarily related to the cost of processing the kidney. The bill, therefore, provides for reimbursement of organ procurement agency and histocompatibility laboratory services on a reasonable cost basis.

In implementing this provision, your committee expects the Secretary to apply recognized principles of cost reimbursement, obtain periodic cost reports, and provide for an intermediary hearing for an agency or laboratory which disagrees with a cost determination. Your committee also expects that the services of these agencies will continue to be reimbursed through the hospital; however, in view of the evolving relationships in this particular field, the Secretary may institute, if he finds it appropriate, a system whereby such agencies are reimbursed directly for their services.

The bill authorizes the Secretary to develop and apply appropriate requirements with respect to providers of services and renal dialysis facilities furnishing dialysis and transplant services. Your committee expects that the Secretary will develop, in addition to such requirements as are currently applicable with respect to such providers and facilities, appropriate requirements relating to the provision of self-dialysis services in a self-care dialysis unit and home dialysis support services furnished by a provider or facility.

INCENTIVE REIMBURSEMENT METHOD FOR SERVICES FURNISHED BY A RENAL DIALYSIS FACILITY TO PATIENTS DIALYZING AT HOME UNDER THE FACILITY'S SUPERVISION

Your committee's bill would provide for the implementation of an incentive reimbursement system with respect to payment for the dialysis of patients dialyzing at home under the supervision of a facility. Under the bill, the Secretary would be authorized to provide for payment on the basis of a target reimbursement rate for home dialysis for all necessary home dialysis medical supplies, equipment, and supportive services (including the services of qualified home dialysis aides), as the medically necessary to enable patients to continue dialyzing in the home setting. Payment would be made to the facility which is supervising the patient's home care and is willing to assume responsibility for obtaining the necessary equipment, arranging for its maintenance, purchasing medical supplies, and arranging for the provision of needed supportive services.

In establishing the home dialysis target rate (which would be adjusted for regional differences), the Secretary would include his estimate of the cost of providing medically necessary home dialysis supplies and equipment (including such medically necessary routine laboratory services as are required); an allowance, in an amount determined by the Secretary, to cover the cost of providing personnel to aid in home dialysis; and an allowance, in an amount determined by the Secretary, to cover the facility's administrative costs and to provide an incentive for the efficient delivery of home dialysis; but in no event may the target rate exceed 70 percent of the national average reimbursement rate (i.e., the average amount approved by medicare before application of the coinsurance requirement), adjusted for regional variations, for institutional maintenance dialysis in the preceding fiscal year. Any target rate so established for a calendar year would not be subject to renegotiation during that year. Moreover, in establishing such a rate, the Secretary would be authorized to utilize a competitive-bid procedure, a prenegotiated rate procedure, or any other procedure he determines is appropriate and feasible.

The implementation of a home dialysis target rate addresses the critical problem of encouraging more efficient delivery (and more effective supervision) of home dialysis services. Because of their responsibilities for overseeing home patients and their desire to budget moneys as adequately as possible to provide all the services they deem necessary for their patient population, your committee believes that facilities would have an incentive under this method to exercise additional restraints on home dialysis costs by implementing more effective purchasing procedures for supplies and equipment and by more rigorously assessing the actual need for particular services. Moreover, all necessary services, supplies, and equipment to perform home dialysis would be controlled under one account maintained by the facility, thereby improving the program's ability to accurately identify home dialysis costs, evaluate the effectiveness of facility management of home care, and provide realistic incentives for cost-effective delivery of services.

Such a reimbursement method offers other significant advantages. In order to qualify for reimbursement under this method, a facility would have to assume full responsibility for the supervision of patients dialyzing at home. This should facilitate improved supervision of the care rendered to home patients. Moreover, since the supervising physician at the facility would have the flexibility to use the reimbursement for home dialysis patients in the manner he determines would be most appropriate medically for each particular patient, more effective management of patient care is possible.

While recognizing that this method represents a new and innovative approach to the management and reimbursement of home dialysis services, your committee believes it offers an opportunity both for facilities and patients to effect economies, while at the same time maintaining a high level of quality care. The concept of an incentive target rate encompasses both of these ideas. Your committee expects, therefore, that the Secretary will implement this reimbursement system prudently with due regard for the need to carefully assess its effects and to assure that services rendered meet the tests of medical necessity and reasonableness.

On the other hand, it is not the committee's intent that the target rates be automatically reduced in cases where facilities have demonstrated effective performance, but rather that such rates be designed so as to assure efficient facilities of an incentive to continue to deliver services on an efficient basis. Thus, in developing the target rates, your committee expects that the Secretary will take into account the differential in the costs involved in the use of peritoneal dialysis, as well as regional variations in the provision of home dialysis services generally, with a view to achieving the purpose of increased and more effective utilization of the home dialysis setting.

D. Peer Review and Program Goals for Patients on Self-Dialysis

Your committee's bill assigns responsibility to the network peer review organizations for encouraging the use of those treatment settings most compatible with the successful rehabilitation of the patient, for establishing network goals for the identification and placement of suitable candidates in self-care settings and transplantation, and for assessing the performance of facilities in meeting these goals. Under the bill, each renal disease network and its medical review board would be responsible for—

(*a*) Developing, on the basis of normative data derived from the renal disease medical information system and criteria and standards developed within the network, network goals relating to the quality and appropriateness of patient care, including goals with respect to the appropriate proportion of network patients dialyzing in self-care settings and undergoing transplantation;

(*b*) Evaluating the procedures by which facilities in the network assess the appropriateness of patients for proposed treatment modalities;

(*c*) Identifying facilities that are not cooperating towards meeting network goals and assisting them to develop plans for correction; and

(*d*) Submitting an annual report to the Secretary on the network's performance in meeting its goals, including data on the comparative performance of facilities with respect to the placement of suitable candidates in self-care settings and transplantation, and the identification of those facilities that have consistently failed to cooperate with network goals; and recommendations with respect to the need for additional or alternative services or facilities in the network in order to meet the network goals.

The Secretary would evaluate the adequacy of each network's goals, in relation to the national objective (as described below), and the performance of the network in meeting these goals, and may recommend such modifications in the goals and the methods for achieving them as he deems appropriate. Where the Secretary determines, on the basis of the data contained in the network's annual report, that a facility has consistently failed to cooperate with network plans and goals, he may terminate or withhold certification of such facility, with respect to payment for renal disease services, until he determines that such facility is making reasonable and appropriate efforts to cooperate with the network's plans and goals. Similarly, the Secretary would be authorized to terminate or withhold certification of a facility which, having been designated as a site for a self-care dialysis training program, fails to provide the required self-care dialysis training.

The bill establishes as the national objective with respect to the appropriate proportion of patients in self-dialysis settings and transplantation that a majority of new patients being accepted for end-stage renal disease treatment should be in self-care dialysis settings or be transplanted. The bill further requires that the Secretary shall, after consultation with appropriate professional and network organizations, and after taking into account available evidence relating to developments in research, treatment methods, and technology, periodically evaluate and, when he determines necessary, recommend revision of the national objective to the Congress.

In addition, the Secretary would be required, in determining whether to certify additional facilities or expansion of existing facilities within a network, to take into account the network's goals and performance as reflected in the network's annual report, and to assure himself that where a network has a low home dialysis treatment percentage, such percentage can be satisfactorily justified before certifying additional beds or facilities.

The continuing decline in the proportion of renal patients on home dialysis represents, in the view of many nephrologists, a dangerous trend. Apart from the serious fiscal implications of the decline, these nephrologists argue that the increased reliance on facility dialysis is creating a passive, dependent generation of patients, unwilling to assume any responsibility for the management of their own care or the direction of their lives. While recognizing that home dialysis is not suitable for a substantial number of renal patients, they nonetheless argue that it is medically feasible for anywhere from 30 to 50 percent of renal patients to manage dialysis at home.

Your committee believes that peer review of decisions on the treatment modality is desirable, and that the development of a long-range national objective for increased use of self-dialysis and transplantation is warranted in view of the decline in the percentage of patients now dialyzing at home and past disincentives to the use of transplantation. Moreover, your committee is persuaded that reasonable goals can be defined realistically—and adjusted in accordance with experience—and that peer review is an appropriate mechanism for attaining them.

The formulation of a national objective with respect to the use of treatment resources and the placement of suitable candidates in self-care settings does not imply any governmental intervention into the patient-physician decisionmaking process in any given case. On the contrary, it is your committee's intent that such decisions remain, as they have always been, in the hands of patients and their physicians and that the evaluation of the procedures for making such decisions rest with appropriate peer review organizations. The stipulation of a national objective represents an intent to assure that such evaluations take place on a continuing basis and that they reflect the most responsible planning and judgment with respect to the best possible use of alternative resources, consistent with the safety and well-being of renal patients. Moreover, the national objective so formulated, while reflecting a high degree of professional consensus on what is potentially attainable, will be periodically reviewed in the light of changing circumstances and knowledge, and can be revised as that knowledge and experience dictates.

E. Studies, Reports and Administration

EXPERIMENTS AND STUDIES

Your committee's bill requires the Secretary to conduct the following studies and experiments: (a) pilot projects relating to the use of durable medical equipment by renal disease patients; (b) experiments and studies to evaluate methods for reducing the costs of the renal disease program, including experimentation with reimbursement for home dialysis aides and evaluations of the cost-saving potential of the reuse of dialysis filters, and the use of methods of dietary control; (c) studies of methods to increase public participation in kidney and other organ donation programs; (d) a study of reimbursement for physician services furnished to renal patients; and (e) a study of possible ways to assist renal patients not eligible for medicare to meet their medical care costs. The Secretary would be required to submit the results of these studies and experiments, along with any recommendations for legislative changes, to the Congress by October 1, 1978.

There is widespread agreement on the need for further study and experimentation with a variety of issues relating to more cost-effective measures for providing renal disease treatment. Many of these issues, such as the reuse of dialysis filters and the utilization of dietary controls, are matters involving differing professional judgments, and it is expected that the Secretary will employ the services of the appropriate professional disciplines in conducting these experiments. In particular, your committee expects that the experiments relating to dietary control will use the expertise of registered dietitians and of board-certified nephrologists who devote a substantial part of their professional practice to problems of patients with end-stage renal disease.

Your committee recognizes that major obstacles to the increased use of transplantation is the problem of an adequate supply of suitable organs. Due to lack of public understanding of the need for organ donation, each year thousands of cadaver organs that are suitable for transplantation are not used. Your committee believes, therefore, that there is a need to find ways to increase public participation in organ donation programs.

ANNUAL REPORT ON RENAL DISEASE PROGRAM

Your committee's bill requires the Secretary to submit a report on the renal diease program to the Congress on October 1, 1978, and on October 1 of each year thereafter. This report is to include data and information on program experience, operations and cost, as well as information on the results of cost-saving experiments and research into the causes, prevention, and treatment of renal disease.

ADMINISTRATION

Your committee's bill clarifies present law by explicitly authorizing the Secretary to establish appropriate organizational and informational structures to effectively administer the program, including renal disease network areas, network organizations to assure professional participation, and a renal disease medical information system. The bill also provides authority for the Secretary to develop mechanisms, consistent with the responsibilities assigned to network organizations and their medical review boards, for the coordination of network planning and quality assurance activities with other health planning and peer review activities authorized under the National Health Planning and Resources Development Act (PL 93–641) and the Professional Standards Review Organization provisions of the Social Security Act and for the exchange of aggregate data and information among these organizations.

Some concern has been expressed about the extent of the Secretary's authority under present law to establish the necessary administrative structures in the renal disease networks to assure professional participation in the planning and review of network goals and performance. The intent of the bill is to eliminate this uncertainty. It is also your committee's intent that medical data derived from this program be governed by the same policies with respect to the confidentiality of individual medical records as are applicable under present law.

F. Minor and Technical Amendments

Your committee's bill includes two minor changes in the rules concerning entitlement to end-stage renal disease.

First, your committee has deleted the requirement in present law that an individual be under 65 years of age to qualify as a renal disease beneficiary. This provision has caused hardship in cases where the onset of renal disease was after 65 and entitlement could only be based on the work of another related individual. The committee's proposed change, of course, would not affect the entitlement of individuals to medicare based on their own work, nor would it impose a 3-month waiting period for entitlement to renal disease benefits on such individuals.

Second, the committee has clarified the intent of present law that individuals with end-stage renal disease be deemed to satisfy the entitlement requirements applicable to medicare disability beneficiaries.

Your committee recognizes that renal disease is a progressive disease; and that in many cases, it may be difficult to decide whether or when maintenance dialysis treatments should be initiated, and the exact point at which a person with a severe kidney disorder can be determined to have end-stage renal disease and thus be entitled to medicare protection. In the medical community, decisions as to appropriate treatment, including the point at which maintenance dialysis is initiated, may be subject to change over time in the light of improved understanding of the disease. Your committee therefore recognizes that there is a need for some flexibility in policies concerning entitlement, termination, and/or reentitlement to medicare. Your committee expects the Secretary to be guided in establishing the necessary rules not only by the need for flexibility, but by the basic purpose of the ESRD program, which is to relieve individuals of the catastrophic costs associated with the treatment of this disease.

Your committee's bill also makes a change in the structure of the Hospital and the Supplementary Medical Insurance Trust Funds' Boards of Trustees by replacing the Commissioner of Social Security with the Administrator of the Health Care Financing Administration as the Secretary of both Boards. Such a change was made necessary by the reorganization of the Department of Health, Education, and Welfare as a result of which responsibility for the administration of medicare program was transferred from the Social Security Administration to the Health Care Financing Administration.

IV. Cost of Carrying Out the Bill and Effect on the Revenues

In compliance with clause 7 of rule XIII of the Rules of the House of Representatives, your committee states that the Health Care Financing Administration of the Department of Health, Education, and Welfare has informed the committee that it "anticipates that the accrued savings that will be realized as a result of increased dialysis in the home setting will offset the cost of the incentives included in the bill. As greater percentages of new patients enter home dialysis, there is a potential for savings in future years." Your committee concurs with the Department's estimate.

In compliance with subdivision (C) of clause (2)(1)(3) of rule XI of the Rules of the House of Representatives, your committee states that the statement relative to the estimated costs of carrying out the bill by the Director of the Congressional Budget Office was requested but has not been timely submitted to the committee for inclusion in the report.

V. Other Matters To Be Discussed Under the House Rules

VOTE OF THE COMMITTEE

In compliance with subdivision (B) of clause 2(1)(2) of rule XI of the Rules of the House of Representatives, the following statement is made relative to the vote of the committee on the motion to report the bill. The bill, H.R. 8423, was ordered favorably reported by a voice vote.

OVERSIGHT FINDINGS

In compliance with subdivision (A) of clause 2(1)(3) of rule XI of the Rules of the House of Representatives, the following statement is made relative to oversight findings by your committee.

In recent years, your committee's Subcommittees on Health and Oversight have conducted extensive examinations of the cost and operation of the medicare end-stage renal disease program. The Oversight Subcommittee held several hearings on the program during the months of June, July, and December 1975. In addition to obtaining data on the scope, cost, and administration of the program, the subcommittee received comments on several bills before the health subcommittee which would amend the program. The subcommittee was also assisted in its review by the General Accounting Office and its report, "Treatment of Chronic Renal Failure: Dialysis, Transplant, Costs and the Need for More Vigorous Efforts," June 24, 1975.

The oversight subcommittee's report of October 22, 1975, on the renal disease program identified a number of significant problems—including the problems of rising costs, declining use of self-dialysis, disincentives to transplantation, insufficient program controls over the expenditure of funds and inadequate application of peer review mechanisms to assure effective use of treatment resources—and suggested a variety of remedies for these persistent difficulties. This report suggested that the health subcommittee review the issues and undertake consideration of appropriate legislative changes in the program.

Subsequently, the health subcommittee conducted public hearings on proposals to amend the renal disease provisions of medicare law. The issues identified in these several hearings, and presented for consideration in legislative proposals and the GAO report, have been addressed by your committee in this bill.

NEW BUDGETARY AUTHORITY AND TAX EXPENDITURES

With respect to subdivision (B) of clause 2(l)(3) of rule XI of the Rules of the House of Representatives, your committee states that the changes made in present law by this bill involve no new budgetary authority or new or increased tax expenditures.

OVERSIGHT BY COMMITTEE ON GOVERNMENT OPERATIONS

With respect to subdivision (D) of clause 2(l)(3) of rule XI of the Rules of the House of Representatives, your committee advises that no oversight findings or recommendations have been submitted to your committee by the Committee on Government Operations with respect to the subject matter contained in the bill.

INFLATIONARY IMPACT

In compliance with clause 2(l)(4) of rule XI of the Rules of the House of Representatives, your committee states that the changes made in existing law by this bill would not have an inflationary impact on prices and costs in the operation of the national economy. It is your committee's belief that the improvements that would be made by the bill in the operation of the renal disease program will in fact significantly restrain the inflationary trend evident in this program in recent years.

VI. Section-by-Section Analysis of the Bill

Section 1

The first section of the bill amends title II of the Social Security Act by adding a new section 226A entitled "Special Provisions Relating to Coverage Under Medicare Program for End State Renal Disease."

New section 226A(a) extends coverage under medicare for hospital insurance and supplementary medical insurance, as disabled individuals, to people who are medically determined to have end stage renal disease and require renal dialysis or a renal transplant. Such individuals must be fully or currently insured under the Social Security Act (or have equivalent railroad employment), or be entitled to monthly social security or railroad retirement benefits, or be the spouse or dependent child of an individual who meets one of the last two requirements. The regular medicare coinsurance, deductible, and premium provisions apply to these people.

Section 226A(b) provides that an individual's entitlement to medicare benefits on the basis of end stage renal disease shall begin with the earlier of (A) the third month afte the month in which a regular course of dialysis is initiated, or (B) the first month in which the individual is admitted to an approved hospital in preparation for or anticipation of kidney transplant surgery, provided that such surgery occurs in that month or in either of the next two months; and shall end, in the case of an individual who receives a kidney transplant, with the thirty-sixth month after the month he receives the transplant, or for an individual who has not received a kidney transplant and no longer requires regular dialysis, with the twelfth month after the month in which the dialysis is terminated.

Section 226A(c)(1) waives the three-month waiting period in subsection (b) for individuals who participate in an approved self-care dialysis training program during the first three months.

Section 226A(c)(2) provides immediate medicare entitlement for individuals who must initiate or resume a regular course of dialysis because of kidney transplant failure.

Section 2

Section 2 of the bill amends part C of title XVIII of the Social Security Act by adding a new section 1881 entitled "Medicare Coverage for End Stage Renal Disease Patients."

Section 1881(a) provides that individuals otherwise eligible for medicare benefits, as well as kidney donors, shall have the same benefits as individuals who are entitled solely because of section 226A.

Section 1881(b)(1) provides that medicare payments for services furnished to individuals determined to have end stage renal disease shall include payments to approved providers of services and dialysis facilities for institutional dialysis services, transplantation services, self-dialysis services in a self-care dialysis unit maintained by the provider or facility, and home dialysis support services furnished by the provider or facility; and payments to or on behalf of such individuals for home dialysis supplies and equipment. The requirements prescribed by the Secretary for providers and facilities furnishing such services shall include requirements for a minimum utilization rate for covered procedures and for self-dialysis training programs.

Section 1881(b)(2)(A) provides that payment under part B of medicare for dialysis services furnished by providers of services and renal dialysis facilities shall be equal to 80 percent of the amounts determined by the Secretary; payments for services provided under part A of medicare shall be determined in accordance with section 1861(v), and with respect to the procurement of organs for transplant from organ procurement agencies or histocompatibility laboratories such costs shall not exceed the costs incurred by the agency or laboratory. A renal dialysis facility must agree to accept medicare payment as payment in full for covered services, except for payment by the individual of the medicare deductible and coinsurance amounts.

Section 1881(b)(2)(B) provides that the Secretary shall prescribe in regulations methods and procedures to determine the costs incurred

(1), (2) and (3) and the studies under paragraphs (4), (5), and (6). Such report shall include any recommendations for legislative changes which the Secretary finds necessary or desirable as a result of such experiments and studies.

(g) The Secretary shall submit to the Congress on October 1, 1978, and on October 1 of each year thereafter, a report on the end stage renal disease program, including but not limited to—

(1) the number of patients, nationally and by renal disease network, on dialysis (self-dialysis or otherwise) at home and in facilities;

(2) the number of new patients entering dialysis at home and in facilities during the year;

(3) the number of facilities providing dialysis and the utilization rates of those facilities;

(4) the number of kidney transplants, by source of donor organ;

(5) the number of patients awaiting organs for transplant;

(6) the number of transplant failures;

(7) the range of costs of kidney acquisition, by type of facility and by region;

(8) the number of facilities providing transplants and the number of transplants performed per facility;

(9) patient mortality and morbidity rates;

(10) the average annual cost of hospitalization for ancillary problems in dialysis and transplant patients, and drug costs for transplant patients;

(11) medicare payment rates for dialysis, transplant procedures, and physician services, along with any changes in such rates during the year and the reasons for those changes;

(12) the results of cost-saving experiments;

(13) the results of basic kidney disease research conducted by the Federal Government, private institutions, and foreign governments;

(14) information on the activities of medical review boards and other network organizations; and

(15) estimated program costs over the next five years.

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Calendar No. 656

95th Congress } SENATE { Report
2d Session } { No. 95–714

END STAGE RENAL DISEASE PROGRAM

March 22 (legislative day, February 6), 1978.—Ordered to be printed

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Mr. Long, from the Committee on Finance,
submitted the following

REPORT

[To accompany H.R. 8423]

The Committee on Finance, to which was referred the bill (H.R. 8423) to amend titles II and XVIII of the Social Security Act to make improvements in the end stage renal disease program presently authorized under section 226 of that act, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

I. PURPOSE AND BACKGROUND OF THE BILL

During the past several years a number of studies and public hearings have been conducted in order to assess the operation and effectiveness of the medicare end stage renal disease program. The results of these efforts indicate that the program has been generally successful in meeting the needs of renal disease patients for protection against the catastrophic costs of dialysis and transportation. However, at the same time, it has become clear that the program is plagued by a number of serious problems which threaten to undermine its continuing stability and effectiveness.

The committee is concerned about the high and steadily rising cost of the program and the burden it can place on the medicare trust funds unless steps are taken to put it on a more cost-effective basis. The committee believes that there are several areas of potential cost savings, including the increased use of self-dialysis settings and tranplantation, where medically appropriate, and the use of incentive reimbursement methods to encourage economies in the delivery of services.

The introduction of appropriate incentives to encourage the medically appropriate use of lower cost treatment modalities is compatible with the best interests of renal disease patients. The patient who successfully undergoes transplantation can return to a relatively normal and stable life. The patient who can successfully manage self-dialysis either in his own home or in a self-care dialysis unit of a facility regains a significant measure of control over his own care and escapes from what might otherwise be a permanently dependent relationship. And in both types of cases, program savings over the long run can be substantial.

The committee wishes to stress its intent that patients who are medically, psychologically, and socially inappropriate for home dialysis are not to be forced, through administrative procedure, into home dialysis. Objective professional judgment, along with the needs and wishes of the patient, should be the principal determinants of the locus of treatment.

II. SUMMARY OF THE BILL

The medicare renal disease program amendments are designed to accomplish four objectives: Provide incentives for the use of lower cost, medically appropriate self-dialysis (particularly home dialysis), as an alternative to high-cost institutional dialysis; eliminate current program disincentives to the use of transplantation; provide for the implementation of incentive reimbursement methods to assure more cost-effective delivery of services to patients dialyzing in institutions and at home; and provide for studies of alternative ways to improve the program and for regular reporting to the Congress on the renal disease program. The summary presented below briefly outlines these principal features of the bill and, in addition, an unrelated medicare amendment which deals with payment for physicians' services in teaching hospitals.

INCENTIVES FOR USE OF SELF-DIALYSIS

Several provisions are designed to provide incentives for more extensive use of lower cost, medically appropriate self-care dialysis settings. Although the cost of treatment in self-dialysis settings is usually considerable less for the program than facility dialysis, there has been a steady decline in the percentage of patients on home dialysis. Experience indicates that one of the reasons for this decline is the existence of financial disincentives, resulting from the benefit structure of the medicare program, for patients to undertake self-dialysis. The bill modifies present law to eliminate these disincentives by:

1. Waiving the present 3-month waiting period for a beneficiary who enters a self-care training program prior to the end of the third month after the month his regular course of dialysis begins;
2. Providing coverage for disposable supplies (such as syringes, needles, and sterile drapes) required for home dialysis;
3. Providing coverage for periodic supportive services, including emergency visits and servicing of dialysis equipment, furnished by facilities to individuals dialyzing at home; and
4. Authorizing full reimbursement to facilities for dialysis equipment purchased by facilities for the exclusive use of patients dialyzing at home.

The bill also provides coverage for services of a self-care dialysis unit maintained by a renal dialysis facility.

ELIMINATE DISINCENTIVES TO TRANSPLANTATION

Several provisions are designed to eliminate disincentives to transplantation which expose transplant candidates to significant financial risk. Thus, the bill provides for:

1. Coverage for a transplant patient beginning with the month he is hospitalized, without regard to the waiting period of present law, if transplant surgery takes place within that month or the following 2 months;
2. Extension of the period of post-transplantation medicare coverage from 12 months to 36 months;
3. Immediate resumption of coverage, without a waiting period, whenever a transplant fails; and
4. Coverage for expenses incurred by live kidney donors, including the period of the donor's recovery.

REIMBURSEMENT METHODS

To assure more cost-effective reimbursement for dialysis services the bill provides for use of incentive reimbursement methods for services furnished by renal dialysis facilities to patients dialyzing in the facility or at home. Such methods may include prospectively set rates, a system for classifying comparable facilities, the use of target rates (adjusted for regional differences) with provision for sharing savings attributable to efficient and effective delivery of services, and other incentives to efficient performance. (The Secretary may use competitive-bid procedures, prenegotiated rate procedures or such other procedures as he finds feasible and appropriate in establishing the home dialysis target rates.)

The bill also clarifies present law concerning the alternative reimbursement methods available to physicians with respect to services provided in connection with routine maintenance dialysis episodes.

STUDIES, REPORTS, AND ADMINISTRATION

The bill requires the Secretary to conduct experiments and studies on ways to reduce program costs, without impairing quality of care, including studies relating to reuse of dialysis filters and the use of dietary controls, to increase public participation in organ donation programs and to assess alternative ways of financing renal disease services. The bill also requires the Secretary to submit an annual report to the Congress on the cost and operation of the program, and on developments in basic and applied research in the field of renal disease. The Secretary is authorized to develop appropriate administrative structures and arrangements to carry out his responsibilities.

TEACHING PHYSICIANS

In a provision whose applicability is not limited to the ESRD portion of medicare, the bill defers the effective date of a previously enacted provision (sec. 227 of P.L. 92–603) which deals with reimbursement under medicare for the services of physicians in teaching hospitals.

MINOR AND TECHNICAL AMENDMENTS

The bill amends the entitlement provisions of present law to clarify the intent that individuals with end stage renal disease are deemed to satisfy the requirements relating to disability beneficiaries. The bill also provides that the Administrator of the Health Care Financing Administration shall serve, in lieu of the Commissioner of Social Security, as the Secretary of the Board of Trustees of the Hospital Insurance and Supplementary Medical Insurance Trust Funds and shall be responsible for making reimbursement to HMO's under the medicare program.

III. GENERAL STATEMENT

A. INCENTIVES FOR USE OF SELF-DIALYSIS

Several provisions are included to provide incentives for more extensive use of lower cost, medically appropriate self-care dialysis settings. Although dialysis can be performed in either the home or in an institutional setting, the choice of dialysis location has significant cost implications. The cost of home dialysis is considerably less than institutional dialysis. Studies indicate that the current annual cost of home dialysis (after the initial year) is about $8,000 while the annual cost of institutional dialysis is around double that figure.

However, since 1972, the year in which the medicare renal disease program was enacted, there has been a steady decline in the percentage of patients on home dialysis. According to the National Dialysis Register, over 40 percent of the total patients on dialysis were dialyzing at home in 1972. By the beginning of 1975, the percentage on home dialysis had declined to 25 percent; and, according to data just released by the Department the decline has continued—as of calendar year 1976, according to this data, less than 10 percent of dialysis patients are on home dialysis. While various reasons for this decline have been offered (including changes in the patient population under treatment, professional disinterest in encouraging home dialysis, and increased access to institutional facilities), evidence suggests that one of the major reasons is the existence of financial disincentives for patients to undertake self-care dialysis.

At the same time that the use of home dialysis has been declining, renal disease program costs have been rising at a significantly higher rate than forecast. Current estimates furnished by the Department indicate that renal disease program costs for fiscal year 1978 will be $0.9 billion and will increase substantially in subsequent years. The following table furnished by the Department illustrates the anticipated increases:

Estimate of annual benefits paid

Fiscal year:	Benefits in billions
1980	$1.3
1982	1.9
1987	3.6
1992	5.3

Moreover, the patient population for which these costs would be incurred is a relatively small one. As of March 1977, about 36,000 renal disease patients were covered by the program. The rate of increase in enrolled beneficiaries is about 4 percent per year and is expected to decline to about one-half of 1 percent by 1985. Thus, it is estimated that the program will have an enrolled renal population of approximately 60,000 by 1986 and a stable population of about 75,000 by the year 2000.

While it is true that the high cost of the program is, in part, a reflection of the costly technology required for treatment, and the need in most cases for lifetime care, it is generally agreed that rising program costs are also a reflection of disincentives in the program to the use of lower cost self-dialysis procedures and settings. Appropriate incentives for more cost-effective use of self-care dialysis settings can help significantly to contain rising program costs without impairing the quality or availability of needed services.

WAIVER OF 3-MONTH WAITING PERIOD FOR SELF-CARE TRAINING

The bill would provide for waiver of the waiting period where an individual begins a self-care training program prior to the end of the third month after the month he initiates a regular course of dialysis.

Under present law, a renal disease patient under age 65 becomes entitled to medicare benefits beginning with the first day of the third month after the month a course of dialysis is initiated. This 3-month waiting period discourages prompt entry into a self-care training program since the beneficiary would also have to bear the additional cost of this training out-of-pocket. Moreover, once adjusted to facility dialysis, patients are often reluctant to make the change to self-care dialysis.

This provision may help to overcome the reluctance on the part of many beneficiaries to undertake self-dialysis training. However, it is expected that the Secretary will take appropriate steps to assure that it is understood the waiver is intended for those individuals who can be reasonably expected to complete the training program and, on completion, to enter into a self-dialysis setting.

COVERAGE OF SUPPLIES NECESSARY TO PERFORM HOME DIALYSIS

The bill provides coverage for all supplies, including disposable supplies, required for the effective performance of home dialysis.

Under present law, home dialysis results in a substantially larger out-of-pocket expense to the patient than facility dialysis. This is so because under the existing medicare benefit structure certain expenses that are covered in an institutional setting are not covered at the patient's home. Where dialysis is done in a facility, for example, disposable items and supplies which are necessary for the performance of dialysis (such as syringes, alcohol wipes, sterile drapes, needles, topical anesthesias, and rubber gloves) and various types of supportive equipment are covered. When dialysis is performed at home, these items—which represent as much as 15 percent of costs incurred by beneficiaries who self-dialyze at home—are not covered and the patient must pay for them out of his personal funds.

Although it has been argued that coverage of disposable items and supplies for renal patients would represent a departure from traditional medicare coverage provisions, there is a precedent for such coverage in the current provision of medicare law under which all colostomy supplies, including disposables, are covered. The reason for extending coverage in both of these cases is the unique nature of the medical procedures involved and the indispensable and continuing need for the supplies in the effective management of the patient's care. Moreover, the committee believes that coverage of renal supplies would eliminate a significant disincentive to home dialysis.

COVERAGE OF HOME DIALYSIS SUPPORT SERVICES

The bill provides coverage for periodic support services, to the extent permitted in regulations, furnished by a renal dialysis facility or hospital to an individual dialyzing at home. Support services could include periodic monitoring of the patient's adaptation to self-dialysis, emergency visits where necessary, help in the installation and maintenance of dialysis equipment and any additional supportive services the Secretary determines will be useful in helping patients to remain on home dialysis.

Under present law, mechanisms do not exist to either monitor actual home dialysis performance or provide backup professional and maintenance assistance in the home. If trained technical personnel (functioning under physician supervision) were permitted to periodically observe the patient's management of his dialysis, assist with difficult access situations, or occasionally function as a dialysis assistant, incentives to continued use of home dialysis would result by precluding the need for unnecessary inpatient treatment or backup institutional dialysis. Moreover, help in maintaining equipment is generally regarded as a vital element in the overall effort to assist those beneficiaries who might otherwise become discouraged by the problems and expense involved in servicing their own equipment to remain on home dialysis.

COVERAGE FOR SERVICES OF A SELF-CARE DIALYSIS UNIT

The bill provides for reimbursement of facilities for the maintenance of a self-dialysis unit in which a patient can manage his own treatment with a lesser degree of ongoing medical supervision and assistance of ancillary personnel than is required for full care maintenance dialysis. Under the bill, a self-dialysis unit must, at a minimum, furnish the services, equipment, and supplies needed for self-care dialysis, have patient-staff ratios which are appropriate to self-dialysis (allowing for such appropriate lesser degree of ongoing medical supervision and assistance) and meet such other requirements as the Secretary may prescribe with respect to the quality and cost-effectiveness of services.

The committee recognizes that many patients who are otherwise motivated to undertake self-dialysis are unable to do so because of physical or social circumstances in the home environment. For such patients the only alternative usually available to them at present is full care maintenance dialysis in an institutional setting.

The committee has, therefore, included in the bill a provision which encourages the use of self-care stations in renal dialysis facilities. Under the bill, the Secretary would be authorized to define what constitutes self-care dialysis outside the home and to identify the institutional settings in which it can be appropriately performed. In defining appropriate self-care dialysis settings, the Secretary is expected to identify those factors which differentiate full-care dialysis from self-care dialysis—for example, staff-to-patient ratios. In addition, the definition of self-care dialysis should specify the types of support services the facility is required to provide as an integral part of self-care, as well as those services which are not required but which would be considered an acceptable part of self-care for reimbursement purposes.

The committee does not intend that there be a proliferation of underutilized self-care units. Thus, it is expected that the Secretary will apply minimum utilization requirements and will take appropriate steps to assure himself that a need exists for the unit before authorizing its reimbursement.

REIMBURSEMENT TO FACILITIES FOR REASONABLE COST OF DIALYSIS EQUIPMENT FOR HOME DIALYSIS PATIENTS

The bill authorizes the Secretary, pursuant to agreements with approved renal dialysis facilities, to reimburse such facilities for the full reasonable cost of the purchase, installation, maintenance and reconditioning for subsequent reuse of artificial kidney and automated dialysis peritoneal machines (including supporting equipment) which are reserved for the exclusive use of medicare patients dialyzing at home. In order to waive the coinsurance amount the Secretary would be required to assure by formal agreement that the provider or facility will: (a) Use the equipment only for medicare patients who dialyze at home; (b) recondition the equipment, as needed, for reuse by other medicare patients; (c) provide full access for the Secretary to all records and information relating to the purchase, maintenance and use of the equipment; and (d) submit such reports as the Secretary may require with respect to the management and use of the equipment. Supporting equipment would include blood pumps, heparin pumps, bubble detectors, other alarm systems and such other items as the Secretary may determine are medically necessary.

As a result of the recent enactment of P.L. 95–142, medicare can make lump-sum payments that cover 80 percent of the reasonable purchase price of durable medical equipment in cases where purchase is more economical than rental. The patient is, of course, expected to pay the remaining 20 percent.

In the case of a $5,000 dialysis machine, patient purchase is difficult or impossible even though purchase would in the long run be most economical for both the medicare program and the patient. In this example, the patient would be faced with financing a coinsurance payment of $1,000. The result is that few home dialysis patients purchase their own equipment. Instead, patients rent equipment. Some rental charges are now running more than $300 per month. In addition, maintenance charges by equipment companies appear to be significantly higher than the cost to facilities to repair their own equipment. Examples provided to the committee show that in many cases, within 1½ to 2 years, the patient and medicare will often pay in rent an amount equal to the total purchase price of the equipment. While many rental contracts provide for the servicing of the equipment and a lowering of the rent and/or an option to buy after several years, the fact remains that rental payments are generally many times the purchase price of the equipment.

While it is difficult to estimate precisely the program saving that might be expected to result from direct purchase, data submitted to the committee indicate that annual savings, even assuming the present proportion of patients on home dialysis, could be as high as $3 million. The committee wishes to emphasize, however, that such savings are attainable on the assumption that the equipment approved for purchase is neither extravagant nor excessive. It is expected, therefore, that the Secretary will develop appropriate criteria and procedures to assure that such equipment as is approved for purchase will be limited to equipment that is sufficient for the medical purposes required and that facilities exercise prudence and sound business practices in the purchase of such equipment.

But perhaps even more important than the direct dollar savings projected on these purchases would be the removal of this significant financial disincentive to home dialysis that is posed by the 20-percent cost sharing applicable to the large purchase and rental charges. The committee believes that the larger savings that would accrue to the program from increased use of home dialysis warrant the use of an arrangement under which approved facilities purchase and maintain dialysis equipment exclusively for the use of patients dialyzing at home. Moreover, utilizing such arrangements with approved facilities will assure the most effective, continued use of this expensive equipment throughout its useful life and a greater degree of professional supervision over the medical management of the patient's home care.

B. Incentives for Renal Transplantation

The cost of a kidney transplant now runs between $20,000 and $25,000. A successful patient would then incur costs of about $3,000 in the first year following transplantation for drugs and physician services, and between $1,000 and $2,000 a year thereafter. Slightly over 3,000 patients (about 10 percent of the renal patient population) attempted transplantation in 1976, and many nephrologists believe that with appropriate encouragement that figure could be significantly increased. The committee believes that the elimination of disincentives to transplantation is essential to assure that patients and their physician have the opportunity to make the important medical choice between dialysis and transplantation unencumbered by financial considerations imposed by the coverage provisions of medicare.

COVERAGE BEGINNING WITH MONTH OF HOSPITALIZATION

The bill modifies present law by beginning coverage for a transplant patient with the month of hospitalization if the surgery takes place within the following 2 months, rather than the following 1 month as under present law. Transplantation is a two-step process: First, the removal of the diseased kidney; second, the implantation of a new kidney which, in some cases, may not take place for as long as 6 to 8 weeks after the first step. A 2-month provision would assure equitable coverage of all transplant patients.

POST-TRANSPLANT COVERAGE EXTENDED TO 36 MONTHS

The bill would extend the period of medicare coverage for patients who undergo transplantation from 12 to 36 months.

Under present law, medicare entitlement for a transplant patient terminates at the end of the 12th month following transplantation. However, a great many transplants have not stabilized or cannot be deemed successful after 12 months. As a result, many patients are either hospitalized or undergoing intensive out-patient treatment for rejection episodes during or shortly after the twelfth month, at the very time their medicare benefits are being terminated. Moreover, even successful transplant patients incur substantial medical costs directly related to the transplant for several years following the surgery, although the heaviest costs are incurred in the first 3 years. The bill would alleviate this problem by affording an adequate period of post-transplant medicare protection.

IMMEDIATE RESUMPTION OF COVERAGE WITHOUT A WAITING PERIOD IF TRANSPLANT FAILS

Under present law, a patient whose transplant fails after his entitlement ends is liable for the substantial costs associated both with the failure of the transplant and any dialysis required during the waiting period before medicare coverage resumes. The bill eliminates this disincentive by providing for the immediate resumption of medicare coverage whenever a transplant is rejected.

CLARIFY PRESENT LAW RELATING TO EXPENSES INCURRED BY KIDNEY DONORS

The bill clarifies the Secretary's authority under present law to provide reimbursement for the costs incurred in connection with kidney donations. The committee believes that such a policy is essential both to assure a continued supply of live donor organs and to take into account, in the medicare reimbursement system, appropriate medical costs related to organ procurement (which cannot always be assigned to a particular beneficiary), including a donor's postoperative recovery costs.

C. Reimbursement Methods

When the Congress enacted the renal disease program in 1972, it did so in full recognition of the fact that substantial difficulties would be encountered in the development of equitable reimbursement policies. Little data was then available either on treatment costs or on prevailing charges. Moreover, there was a great variety of arrangements through which services in the relatively new field of renal dialysis were rendered. As a result, the Congress authorized the Secretary to develop and apply reimbursement policies and procedures on the basis of evolving experience. Based on this extensive program experience the committee believes that several changes that would result in more cost-effective reimbursement can be made both in the method for paying facilities for dialysis services rendered to patients dialyzing in the facility, and in the method by which payment is made for expenses incurred by patients dialyzing at home under the supervision of approved facilities. In addition, it is now appropriate to clarify present law relating to the alternative reimbursement methods available to renal physicians.

ALTERNATIVE REIMBURSEMENT METHODS FOR PHYSICIANS' SERVICES

The bill clarifies the Secretary's authority under present law to provide reimbursement for physicians' services in connection with routine maintenance dialysis in accordance with alternative reimbursement methods.

Under present program policies, physicians have a choice between two methods for receiving reimbursement for routine maintenance dialysis services. Under one method, the physician can bill the medicare program reasonable charges for all emergency services he furnishes during a maintenance dialysis episode; the physician looks to the facility for payment for his routine dialysis services and the facility is reimbursed for these payments by the program.

The second method, called "comprehensive reimbursement," provides for payment of a reasonable charge for all medical services furnished to a maintenance dialysis patient during a month, other than inpatient hospital services and services not related to the patient's renal problem that require extra visits. (Reasonable charges for these latter services may be billed separately.) About one-fourth of all nephrologists have elected this method of reimbursement.

Use of these optional reimbursement methods is consistent with the congressional intent to develop reimbursement methods and procedures designed to address the unique circumstances involved in the provision of maintenance dialysis services.

REIMBURSEMENT FOR RENAL DIALYSIS PROVIDED IN A DIALYSIS FACILITY

The bill modifies present law by directing the Secretary of HEW to promulgate regulations establishing an incentive reimbursement system with respect to dialysis services furnished by facilities to patients dialyzing in the facility. The new reimbursement system would provide appropriate incentives for encouraging more efficient and effective delivery of dialysis services, including (to the extent and in such combination as he determines feasible), the use of prospectively set rates, a system for classifying comparable facilities (taking into consideration in various facilities of the relative complexity, or lack of complexity generally characteristic of their patients' renal treatment needs), target rates with arrangements for sharing such reductions in cost as may be attributable to more efficient and effective delivery of services, and such other incentives as he finds will encourage more cost-effective delivery consistent with proper care. The incentive reimbursement system, which may be established on a cost-related or other equitable and economically efficient basis, would become effective with respect to a facility's first accounting period after the 12th month following the month of enactment.

The Secretary should also establish appropriate limits on reimbursement options which may be elected by facilities so as to preclude shifting back-and-forth from one method to another by facilities so as to maximize reimbursement. The bill authorizes the Secretary to prescribe in regulations such methods and procedures as are necessary to determine costs incurred in furnishing renal dialysis services and to determine amounts payable in accordance with the incentive reimbursement system. Moreover, such regulations, in the case of services furnished by proprietary facilities may include, if the Secretary finds it feasible and appropriate, provision for recognition of a reasonable rate of return on net equity capital, providing such rate of return does not exceed the rate currently provided for in the Social Security Act for other proprietary institutions participating in the medicare program.

The bill addresses these problems directly by providing for the implementation of an incentive reimbursement method designed to encourage facilities to deliver services on a cost-effective basis. To an increasing degree, congressional attention has been focused on the need to develop prospective reimbursement methods and target rates to encourage more efficient management of health facilities and to stimulate better planning in the delivery of services. The method included in the bill reflects this general philosophy; it provides for the use of prospectively set rates and for the use of arrangements under which efficiently managed facilities may share in the savings they produce.

Although the bill authorizes the use of various types of incentives for more efficient delivery of services, it is recognized that some testing and phasing-in of these incentives may be necessary. Thus, the bill authorizes the implementation of incentives in such combination and in accordance with such timing as the Secretary finds administratively feasible, consistent with the intent to establish at least an initial incentive reimbursement system no later than a year after enactment.

In addition, the bill clarifies the Secretary's authority under present law to (a) require facilities reimbursed on a cost-related basis to agree not to charge beneficiaries more for covered services they provide than the applicable deductible and coinsurance amounts, and (b) to provide for reimbursement to hospitals for their costs attributable to payments made to an organ procurement agency or histocompatibility laboratory in amounts that may not exceed costs incurred by that agency or laboratory. The bill further provides that renal dialysis facilities reimbursed on a cost-related basis will have the same appeal rights as hospitals and other providers of services now have under medicare when a disagreement results with respect to program reimbursement.

The two criticisms most often made of the present "reasonable charges" method for reimbursing renal dialysis facilities is that (1) it does not permit the program to effectively adjust payment limits as prices and circumstances vary or as new facilities come into operation; and (2) it allows facilities to receive reimbursement based on their own charges regardless of the relationship to cost. The congressional intent was to provide for the development of a "charges related to reasonable cost" method of reimbursement for dialysis facilities based on appropriate cost data collected from the facilities by the Secretary. However, efforts to obtain this cost data in accordance with congressional intent have been challenged by some facilities. Accordingly the committee believes that reiteration of the Secretary's authority to collect such cost information is necessary.

Consistent with the provision for cost-related reimbursement, the bill reaffirms the Secretary's authority to reimburse a facility for furnishing covered services under the program only if the facility accepts such payment as payment in full, except for applicable deductible and coinsurance amounts. The facility could, of course, charge the beneficiary or other party for noncovered services.

The committee expects that the Secretary will continue to require renal dialysis facilities to furnish such reports and information concerning the costs of their operations as a condition of reimbursement. The Secretary is also authorized to condition participation upon their compliance with such other requirements relating to program participation as are specified in the Social Security Act and regulations promulgated in accordance with it, including notification to the Secretary if a facility can no longer meet the conditions for participation as an approved supplier or if it contemplates the expansion or addition of services. These requirements will help assure the orderly expansion of facility treatment resources and prevent wasteful duplication of services by precluding expansion without the express approval of the Secretary. The committee believes these requirements should help to restrain the cost escalation of the program by assuring maximum utilization of existing facilities, personnel, and equipment.

The committee realizes that disputes may arise with respect to determinations of the costs incurred by renal dialysis facilities and the amounts payable under the program. The medicare intermediary appeals process should suffice to resolve disputes involving small amounts. Where the amounts in controversy are substantial—$10,000 or more for an individual facility, or $50.000 or more in the aggregate for a group of facilities—the committee has provided that renal dialysis facilities may appeal to the Provider Reimbursement Review Board.

Under present law, pretransplant services furnished by organ procurement agencies and histocompatibility laboratories are reimbursed as inpatient hospital services at the time of transplantation. This policy has been effective in providing coverage of pretransplant services; however, it has not provided the program with adequate fiscal controls. For example, when an organ procurement agency provides a kidney to a transplant hospital, it is billed to the hospital directly and the components of the charge are not subject to the review of the medicare intermediary as are other services provided directly by the hospital. In addition, a kidney may be handled by several agencies before it is delivered to the transplant hospital and each agency will add an amount to the charge which is not necessarily related to the cost of processing the kidney. The bill, therefore, provides for reimbursement of organ procurement agency and histocompatibility laboratory services on a reasonable cost basis.

In implementing this provision, it is expected that the Secretary will apply recognized principles of cost reimbursement, obtain periodic cost reports, and provide for an intermediary hearing for an agency or laboratory which disagrees with a cost determination. The committee also expects that the services of these agencies will continue to be reimbursed through the hospital; however, in view of the evolving relationships in this particular field, the Secretary may institute, if he finds it appropriate, a system whereby such agencies are reimbursed directly for their services.

The bill authorizes the Secretary to develop and apply appropriate requirements with respect to providers of services and renal dialysis facilities furnishing dialysis and transplant services. The committee expects that the Secretary will develop, in addition to such requirements as are currently applicable with respect to such providers and facilities, appropriate requirements relating to the provision of self-dialysis services in a self-care dialysis unit and home dialysis support services furnished by a provider or facility.

REIMBURSEMENT TO RENAL DIALYSIS FACILITIES FOR PATIENTS DIALYZING AT HOME

The bill would provide for the implementation of an incentive reimbursement system with respect to payment for the dialysis of patients dialyzing at home under the supervision of a facility. Under the bill, the Secretary would be authorized to provide for payment on the basis of a target reimbursement rate for home dialysis for all necessary home dialysis medical supplies, equipment, and supportive services (including the services of qualified home dialysis aides), as are medically necessary to enable patients to continue dialyzing in the home setting. Payment would be made to the facility which is supervising the patient's home care and is willing to assume responsibility for obtaining the necessary equipment, arranging for its maintenance, purchasing medical supplies, and arranging for the provision of needed supportive services.

In establishing the home dialysis target rate (which would be adjusted for regional differences), the Secretary would include his estimate of the cost of providing medically necessary home dialysis supplies and equipment (including such medically necessary routine laboratory services as are required); an allowance, in an amount determined by the Secretary, to cover the cost of providing personnel to aid in home dialysis; and an allowance, in an amount determined by the Secretary, to cover the facility's administrative costs and to provide an incentive for the efficient delivery of home dialysis; but in no event may the target rate exceed 70 percent of the national average reimbursement rate (i.e., the average amount approved by medicare before application of the coinsurance requirement), adjusted for regional variations, for institutional maintenance dialysis in the preceding fiscal year. Any target rate so established for a calendar year would not be subject to renegotiation during that year. Moreover, in establishing such a rate, the Secretary would be authorized to utilize a competitive-bid procedure, a prenegotiated rate procedure, or any other procedure he determines is appropriate and feasible.

The implementation of a home dialysis target rate addresses the critical problem of encouraging more efficient delivery (and more effective supervision) of home dialysis services. Because of their responsibilities for overseeing home patients and their desire to budget moneys as adequately as possible to provide all the services they deem necessary for their patient population, the committee believes that facilities would have an incentive under this method to exercise additional restraints on home dialysis costs by implementing more effective purchasing procedures for supplies and equipment and by more rigorously assessing the actual need for particular services. Moreover, all necessary services, supplies, and equipment to perform home dialysis would be controlled under one account maintained by the facility, thereby improving the program's ability to accurately identify home dialysis costs, evaluate the effectiveness of facility management of home care, and provide realistic incentives for cost-effective delivery of services.

Such a reimbursement method offers other significant advantages. In order to qualify for reimbursement under this method, a facility would have to assume full responsibility for the supervision of patients dialyzing at home. This should facilitate improved supervision of the care rendered to home patients. Moreover, since the supervising physician at the facility would have the flexibility to use the reimbursement for home dialysis patients in the manner he determines would be most appropriate medically for each particular patient, more effective management of patient care is possible.

While recognizing that this method represents a new and innovative approach to the management and reimbursement of home dialysis services, the committee believes it offers an opportunity both for facilities and patients to effect economies, while at the same time maintaining a high level of quality care. The concept of an incentive target rate encompasses both of these ideas. The committee expects, therefore, that the Secretary will implement this reimbursement system prudently with due regard for the need to carefully assess its effects and to assure that services rendered meet the tests of medical necessity and reasonableness.

On the other hand, it is not the committee's intent that the target rates be automatically reduced in cases where facilities have demonstrated effective performance, but rather that such rates be designed so as to assure efficient facilities of an incentive to continue to deliver services on an efficient basis. Thus, in developing the target rates, it is expected that the Secretary will take into account the differential in the costs involved in the use of peritoneal dialysis, as well as regional variations in the provision of home dialysis services generally, with a view to achieving the purpose of increased and more effective utilization of the home dialysis setting.

D. Peer Review

The bill assigns to the network peer review organization (a coordinating council, it's executive committee and a medical review board) the responsibility for encouraging the use of those treatment settings most compatible with the successful rehabilitation of the patient, and placement of suitable candidates in self-care settings and transplantation. Under the bill, each renal disease network and its medical review board would be responsible for—

(*a*) Developing criteria and standards relating to the quality and appropriateness of patient care, and

(*b*) Evaluating the procedures by which facilities in the network assess the appropriateness of patients for proposed treatment modalities.

Recognizing the active and continuing role that renal patients play in their own treatment, the committee has added to the House bill a provision that at least one patient representative be included on each network coordinating council and on the council's executive committee.

Present law is silent about the eligibility of individuals who have a financial interest in a renal dialysis facility to serve on renal network coordinating councils, their executive committees and medical review boards. To avoid conflicts of interest, the committee has added to the House bill a provision that would bar from serving on one of these network organizations any individual, or a member of his family who has a significant ownership or control interest in a dialysis institution or who has been paid compensation by such an institution in excess of what could be considered to be reasonable when compared to any services or goods he may have supplied to the facility.

E. STUDIES, REPORTS AND ADMINISTRATION

EXPERIMENTS AND STUDIES

The bill requires the Secretary to conduct the following studies and experiments: (a) pilot projects relating to the use of durable medical equipment by renal disease patients; (b) experiments and studies to evaluate methods for reducing the costs of the renal disease program, including experimentation with reimbursement for home dialysis aides and evaluations of the cost-saving potential of the reuse of dialysis filters, and the use of methods of dietary control; (c) studies of methods to increase public participation in kidney and other organ donation programs; (d) a study of reimbursement for physician services furnished to renal patients; and (e) a study of possible ways to assist renal patients not eligible for medicare to meet their medical care costs. The Secretary would be required to submit the results of these studies and experiments, along with any recommendations for legislative changes, to the Congress by October 1, 1979.

There is widespread agreement on the need for further study and experimentation with a variety of issues relating to more cost-effective measures for providing renal disease treatment. Many of these issues, such as the reuse of dialysis filters and the utilization of dietary controls, are matters involving differing professional judgments, and it is expected that the Secretary will employ the services of the appropriate professional disciplines in conducting these experiments. In particular, the committee expects that the experiments relating to dietary control will use the expertise of registered dietitians and of board-certified nephrologists who devote a substantial part of their professional practice to problems of patients with end stage renal disease. Moreover, the committee has added to the House bill a provision that would assure that experiments in the reuse of dialysis filters would be conducted only after the Secretary of HEW has determined, following review by appropriate authorities such as the FDA, the Center for Disease Control or the National Institutes of Health, that the study will be carried out under circumstances that will assure that the filter reuse will be safe and medically appropriate.

The committee recognizes that major obstacles to the increased use of transplantation is the problem of an adequate supply of suitable organs. Due to lack of public understanding of the need for organ donation, each year thousands of cadaver organs that are suitable for transplantation are not used. The committee believes, therefore, that there is a need to find ways to increase public participation in organ donation programs.

ANNUAL REPORT ON RENAL DISEASE PROGRAM

The bill requires the Secretary to submit a report on the renal disease program to the Congress on October 1, 1978, and on October 1 of each year thereafter. This report is to include data and information on program experience, operations and cost, as well as information on the results of cost-saving experiments and research into the causes, prevention, and treatment of renal disease.

ADMINISTRATION

The bill clarifies present law by explicitly authorizing the Secretary to establish appropriate organizational and informational structures to effectively administer the program, including renal disease network areas, network organizations to assure professional participation, and a renal disease medical information system. The bill also provides authority for the Secretary to develop mechanisms, consistent with the responsibilities assigned to network organizations and their medical review boards, for the coordination of network planning and quality assurance activities with other health planning and peer review activities authorized under the National Health Planning and Resources Development Act (Public Law 93-641) and the Professional Standards Review Organization provisions of the Social Security Act and for the exchange of aggregate data and information among these organizations.

Some concern has been expressed about the extent of the Secretary's authority under present law to establish the necessary administrative structures in the renal disease networks to assure professional participation in the planning and review of network performance. The intent of the bill is to eliminate this uncertainty. It is also the committee's intent that medical data derived from this program be governed by the same policies with respect to the confidentiality of individual medical records as are applicable under present law.

F. REIMBURSEMENT FOR SERVICES OF PHYSICIANS PROVIDED IN TEACHING HOSPITALS

When medicare was enacted, the general expectation reflected in the law was that the patient care services of physicians would be reimbursed under part B (supplementary medical insurance) on the basis of reasonable charges. Hospital costs, including salaries of interns and residents, as well as supervising physicians participating in educational program in the hospital, were to be reimbursed under part A of medicare (hospital insurance) on a reasonable cost basis.

These distinctions, however, are not easily made with respect to services in a teaching hospital, where teaching and patient care are often inseparable. The original medicare law did not address the specific issue of how medicare should determine reimbursement for the services of a physician when he supervises interns and residents in the care of patients.

This ambiguity led in practice to a variety of arrangements for reimbursing the services of physicians in teaching hospitals. Out of concern about the lack of uniformity in these arrangements and reimbursement improprieties the Congress included a provision (section 227) in the 1972 social security amendments (Public Law 92-603) that was intended to remedy these problems.

Adoption of this provision, however, brought forth expressions of serious concern from the medical education community about whether the legislation in fact established a workable and equitable reimbursement policy for the teaching hospital setting and the effective date of the provision has been deferred to provide time for study. The committee has added to the House bill an amendment that would further defer the effective date until October 1, 1978. This delay was requested by the administration to afford it additional time to publish the necessary implementing regulations and to propose possible legislative changes.

G. MINOR AND TECHNICAL AMENDMENTS

The bill includes two minor changes in the rules concerning entitlement to end stage renal disease.

First, the bill deletes the requirement in present law that an individual be under 65 years of age to qualify as a renal disease beneficiary. This provision has caused hardship in cases where the onset of renal disease was after 65 and entitlement could only be based on the work of another related individual. The committee's proposed change, of course, would not affect the entitlement of individuals to medicare based on their own work, nor would it impose a 3-month waiting period for entitlement to renal disease benefits on such individuals.

Second, the committee has clarified the intent of present law that individuals with end stage renal disease be deemed to satisfy the entitlement requirements applicable to medicare disability beneficiaries.

The committee recognizes that renal disease is a progressive disease; and that in many cases, it may be difficult to decide whether or when maintenance dialysis treatments should be initiated, and the exact point at which a person with a severe kidney disorder can be determined to have end stage renal disease and thus be entitled to medicare protection. In the medical community, decisions as to appropriate treatment, including the point at which maintenance dialysis is initiated, may be subject to change over time in the light of improved understanding of the disease. The bill therefore recognizes that there is a need for some flexibility in policies concerning entitlement, termination, and/or reentitlement to medicare. The committee expects the Secretary to be guided in establishing the necessary rules not only by the need for flexibility, but by the basic purpose of the ESRD program, which is to relieve individuals of the catastrophic costs associated with the treatment of this disease.

The bill also makes a change in the structure of the Hospital and the Supplementary Medical Insurance Trust Funds' Boards of Trustees and, under a committee amendment, in the name of the agency responsible for making medicare payments to HMO's, by replacing the Commissioner of Social Security with the Administrator of the Health Care Financing Administration. Such a change was made necessary by the reorganization of the Department of Health, Education, and Welfare as a result of which responsibility for the administration of medicare program was transferred from the Social Security Administration to the Health Care Financing Administration.

The committee added to the House bill technical amendments that are necessary to carry out the intent of the Medicare-Medicaid Anti-Fraud and Abuse Amendments (Public Law 95–142). One of the changes would extend to patients of intermediate care facilities the protection afforded the personal funds of patients in extended care facilities.

IV. REGULATORY IMPACT OF THE BILL

In compliance with paragraph 5 of rule XXIX of the Standing Rules of the Senate, the following statements are made concerning the regulatory impact of the bill.

The provisions of the bill should not act to bring about major and continuing regulatory activity following issuance of the initial regulation modifying present law. Virtually no additional paperwork requirements are anticipated with respect to patients and providers. No change in the personal privacy aspects of the program under present law are expected as a consequence of this legislation.

V. VOTE OF THE COMMITTEE IN REPORTING THE BILL

In compliance with section 133 of the Legislative Reorganization Act of 1946, the following statement is made relative to the vote by the committee to report the bill.

The bill was ordered reported by a voice vote.

VI. BUDGETARY IMPACT OF THE BILL

In compliance with section 252(a) of the Legislative Reorganization Act of 1970 and sections 308 and 403 of the Congressional Budget Act, the following statements are made relative to the costs and budgetary impact of the bill.

The provisions of the bill do not provide new budget authority or tax expenditures. The committee accepts the estimates of the Congressional Budget Office on the impact of the bill. The report received by the committee from the Congressional Budget Office is included in this report.

Congressional Budget Office,
U.S. Congress,
Washington, D.C., March 6, 1978.

Hon. Russell Long,
Chairman, Committee on Finance,
Washington, D.C.

Dear Mr. Chairman: Pursuant to Section 403 of the Congressional Budget Act of 1974, the CBO has reviewed H.R. 8423 as ordered reported by your committee. This bill amends Titles II and XVIII of the Social Security Act to make improvements in the end stage renal disease program (E.S.R.D.) in order to encourage and facilitate the use of home dialysis. Also, H.R. 8423 provides for improved coverage for eligible patients receiving kidney transplants.

Provisions of this bill are intended to increase both the support services and equipment available to home dialysis patients in order to expand the number of individuals who would take advantage of the lower cost method of treatment rather than more expensive institutional dialysis services. Thus, while increasing medicare costs through provision of services and equipment, these expenses would be somewhat offset by the reduced number of institutionally treated E.S.R.D. patients.

It is difficult to estimate both the specific costs attributable to the individual section of H.R. 8423 and the savings due to the higher participation rate of home dialysis beneficiaries. CBO has reviewed the estimates prepared by the H.E.W. Office of the Actuary and believes that they are reasonable. However, they assume full year effects of the bill in fiscal years 1979 and 1980 and, given the lag in bringing participation rates up to the projected 10 percent level, estimates for both costs and savings might be too high. Using the actuaries' estimates as a base, however, CBO would project that costs and savings would essentially offset each other in fiscal year 1979 and, thus, no net increases or decreases over current law would occur. Savings in the second year of about $10 million would accrue, and in subsequent years, given both a reduction in start-up costs and increases in participation, larger savings in the range of $30–40 million would occur.

If we can be of further assistance in this matter, please do not hesitate to contact us.

Sincerely,

ALICE M. RIVLIN, *Director.*

VII. CHANGES IN EXISTING LAW

In compliance with paragraph 4 of rule XXIX of the Standing Rules of the Senate, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT, AS AMENDED

* * * * * * *

TITLE II—FEDERAL OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS

* * * * * * *

Entitlement to Hospital Insurance Benefits

SEC. 226.

(a) Every individual who—

(1) has attained age 65, and

(2) is entitled to monthly insurance benefits under section 202 or is a qualified railroad retirement beneficiary,

Definitions

SEC. 1905. For purposes of this title—

* * * * * * *

(c) For purposes of this title the term "intermediate care facility" means an institution which (1) is licensed under State law to provide, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities, (2) meets such standards prescribed by the Secretary as he finds appropriate for the proper provision of such care, [and] (3) meets such standards of safety and sanitation as are established under regulation of the Secretary in addition to those applicable to nursing homes under State law, *and (4) meets the requirements of section 1861(j)(14) with respect to protection of patients personal funds.* The term "intermediate care facility" also includes any skilled nursing facility or hospital which meets the requirements of the preceding sentence. The term "intermediate care facility" also includes a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts, but only with respect to institutional services deemed appropriate by the State. The term "intermediate care facility" also includes any institution which is located in a State on an Indian reservation and is certified by the Secretary as meeting the requirements of clauses [(2) and (3)] *clauses (2), (3) and (4)* of this subsection and providing the care and services required under clause (1). With respect to services furnished to individuals under age 65, the term "intermediate care facility" shall not include, except as provided in subsection (d), any public institution or distinct part thereof for mental diseases or mental defects.

* * * * * * *

Excerpts From Public Law 93-233, As Amended

* * * * * * *

Payment for Services of Physicians Rendered in a Teaching Hospital

SEC. 15. (a)(1) Notwithstanding any other provision of law, the provisions of section 1861(b) of the Social Security Act, shall, subject to subsection (b) of this section, for the period with respect to which this paragraph is applicable, be administered as if paragraph (7) of such section read as follows:

> "(7) a physician where the hospital has a teaching program approved as specified in paragraph (6), if (A) the hospital elects to receive any payment due under this title for reasonable costs of such services, and (B) all physicians in such hospital agree not to bill charges for professional services rendered in such hospital to individuals covered under the insurance program established by this title.".

(2) Notwithstanding any other provision of law, the provisions of section 1832(a)(2)(B)(i) of the Social Security Act, shall, subject to subsection (b) of this section, for the period with respect to which this paragraph is applicable, be administered as if subclause II of such section read as follows:

> "(II) a physician to a patient in a hospital which has a teaching program approved as specified in paragraph (6) of section 1861(b) (including services in conjunction with the teaching programs of such hospital whether or not such patient is an inpatient of such hospital), where the conditions specified in paragraph (7) of such section are met, and".

* * * * * * *

(d) The provisions of subsection (a) shall apply with respect to cost accounting periods beginning after June 30, 1973, and prior to October 1, [1977] *1978.*

Excerpts From Public Law 95–142

* * * * * * *

Delay In, and Waiver of, Imposition of Reduction of Federal Medical Assistance Percentage Due to a State's Failure to Have an Effective Medicaid Utilization Control Program

SEC. 20. (a) * * *

* * * * * * *

(c)(1) Except as provided in paragraph (2), the amendments made by this section shall be effective on October 1, 1977, and the Secretary of Health, Education, and Welfare shall promptly adjust payments made to States under section 1903 of the Social Security Act to reflect the changes made by such amendments.

(2) The amount of any reduction in the Federal medical assistance percentage of a State, otherwise required to be imposed under section 1903(g)(1) of the Social Security Act because of an unsatisfactory or invalid showing made by the State with respect to a calendar quarter beginning on or after January 1, 1977, shall be determined under such section as amended by this section. Subparagraph (B) of paragraph (4) of section [1905(g)] *1903(g)* of such Act, as added by this section, shall apply to any showing made by a State under such section with respect to a calendar quarter beginning on or after January 1 1977.

* * * * * *

Finder's Aid

P.L. 95-472 (92 Stat. 1332) Approved October 17, 1978

Subject	SS Act Section	P.L. Section	92 Stat.	H.Rep. 95-744	S.Rep. 95-1113
Inserts "or" (Technical Amendment)	209(o)	3(c)(3)	1333	--	--
Excluding Payments From Group Legal Service Plans	209(p)	3(c)(3)	1333	--	--

Public Law 95-472
95th Congress

An Act

o amend section 7447 of the Internal Revenue Code of 1954 with respect to the revocation of an election to receive retired pay as a judge of the Tax Court.

Oct. 17, 1978
[H.R. 8811]

U.S. Tax Court, judges' retirement pay.
26 USC 7447.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That section 7447 of the Internal Revenue Code of 1954 (relating to retirement of Tax Court judges) is amended by adding at the end thereof the following new subsection:

"(i) Revocation of Election To Receive Retired Pay.—

"(1) In general.—Notwithstanding subsection (e)(2), an individual who has filed an election to receive retired pay under subsection (d) may revoke such election at any time before the first day on which retired pay (or compensation under subsection (c) in lieu of retired pay) would (but for such revocation) begin to accrue with respect to such individual.

"(2) Manner of revoking.—Any revocation under this subsection shall be made by filing a notice thereof in writing with the Civil Service Commission. The Civil Service Commission shall transmit to the chief judge a copy of each notice filed under this subsection.

"(3) Effect of revocation.—In the case of any revocation under this subsection—

"(A) for purposes of this section, the individual shall be treated as not having filed an election to receive retired pay under subsection (d),

26 USC 7448.

"(B) for purposes of section 7448—

"(i) the individual shall be treated as not having filed an election under section 7448(b), and

"(ii) section 7448(g) shall not apply, and the amount credited to such individual's account (together with interest at 4 percent per annum to December 31, 1947, and 3 percent per annum thereafter, compounded on December 31 of each year to the date on which the revocation is filed) shall be returned to such individual,

"(C) no credit shall be allowed for any service as a judge of the Tax Court unless with respect to such service either there has been deducted and withheld the amount required by the civil service retirement laws or there has been deposited in the Civil Service Retirement and Disability Fund an amount equal to the amount so required, with interest,

"(D) the Tax Court shall deposit in the Civil Service Retirement and Disability Fund an amount equal to the additional amount it would have contributed to such Fund but for the election under subsection (e), and

"(E) if subparagraph (D) is complied with, service on the Tax Court shall be treated as service with respect to which deductions and contributions had been made during the period of service."

26 USC 7447 note.

Sec. 2. (a) The amendment made by the first section of this Act shall

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apply with respect to revocations made after the date of the enactment of this Act.

26 USC 7447.

(b) Any individual who elects to revoke under section 7447(i) of the Internal Revenue Code of 1954 within one year after the date of enactment of this Act shall be treated as having the requisite current service for purposes of redepositing funds in the Civil Service Retirement and Disability Fund and for purposes of reviving creditable service under subchapter III of chapter 83 of title 5 of the United States Code.

5 USC 8331.

SEC. 3. TREATMENT OF GROUP LEGAL SERVICE PLAN CONTRIBUTIONS FOR PURPOSES OF UNEMPLOYMENT AND SOCIAL SECURITY TAXES.

26 USC 3306.

(a) Section 3306(b) of the Internal Revenue Code of 1954 (relating to the definition of wages for purposes of the Federal Unemployment Tax Act) is amended—

(1) by striking out "or" at the end of paragraph (10);

(2) by striking out the period at the end of paragraph (11) and inserting in lieu thereof "; or"; and

(3) by adding at the end thereof the following new paragraph:

"(12) any contribution, payment, or service, provided by an employer which may be excluded from the gross income of an employee, his spouse, or his dependents, under the provisions of section 120 (relating to amounts received under qualified group legal services plans).".

26 USC 120.

26 USC 3121.
26 USC 3101 *et seq.*

(b) Section 3121(a) of such Code (relating to the definition of wages for purposes of the Federal Insurance Contributions Act) is amended—

(1) by striking out "or" at the end of paragraph (15);

(2) by striking out the period at the end of paragraph (16) and inserting in lieu thereof "; or"; and

(3) by adding at the end thereof the following new paragraph:

"(17) any contribution, payment, or service provided by an employer which may be excluded from the gross income of an employee, his spouse, or his dependents, under the provisions of section 120 (relating to amounts received under qualified group legal services plans).".

42 USC 409.

(c) Section 209 of the Social Security Act is amended—

(1) by striking out "or" at the end of subsection (n);

(2) by striking out the period at the end of subsection (o) and inserting in lieu thereof "; or"; and

(3) by inserting after subsection (o) and before the sentence beginning with "For purposes of this title, in the case of domestic service" the following new subsection:

"(p) Any contribution, payment, or service, provided by an employer which may be excluded from the gross income of an employee, his spouse, or his dependents, under the provisions of section 120 of the Internal Revenue Code of 1954 (relating to amounts received under qualified group legal services plans).".

26 USC 3121 note.

(d) The amendments made by this section shall apply with respect to taxable years beginning after December 31, 1976.

graph (1) shall be deemed to have occurred immediately before the compulsory or involuntary conversion.".

(c) CONFORMING AMENDMENT.—Paragraph (1) of section 2032 A(f) of such Code (relating to period of limitations) is amended by inserting "(or if later in the case of an involuntary conversion to which an election under subsection (h) applies, 3 years from the date the Secretary is notified of the replacement of the converted property or of an intention not to replace)" immediately before ", and". 26 USC 2032A.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to involuntary conversions after December 31, 1976. 26 USC 1016 note.

Approved October 17, 1978.

LEGISLATIVE HISTORY:

HOUSE REPORT No. 95-744 (Comm. on Ways and Means).
SENATE REPORT No. 95-1113 (Comm. on Finance).
CONGRESSIONAL RECORD, Vol. 124 (1978):
  Jan. 24, considered and passed House.
  Aug. 23, considered and passed Senate, amended.
  Sept. 19, House concurred in Senate amendments with amendments.
  Sept. 28, Senate concurred in House amendments.

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95TH CONGRESS } HOUSE OF REPRESENTATIVES { REPORT
1st Session } { No. 95–744

REVOCABILITY OF ELECTION TO RECEIVE RETIRED PAY AS JUDGE OF TAX COURT

OCTOBER 25, 1977.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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Mr. ULLMAN, from the Committee on Ways and Means, submitted the following

REPORT

[To accompany H.R. 8811]

The Committee on Ways and Means, to whom was referred the bill (H.R. 8811) to amend section 7447 of the Internal Revenue Code of 1954 with respect to the revocation of an election to receive retired pay as a judge of the Tax Court, having considered the same, reports favorably thereon with amendments and recommends that the bill as amended do pass.

The amendments (stated in terms of the page and line numbers of the introduced bill) are as follows:

Page 2, strike out lines 15 through 17 and insert:

> "(B) for purposes of section 7448—
>
> "(i) the individual shall be treated as not having filed an election under section 7448(b), and
>
> "(ii) section 7448(g) shall not apply, and the amount credited to such individual's account (together with interest at 4 percent per annum thereafter, compounded on December 31 of each year to the date on which the revocation is filed) shall be returned to such individual,

No material re social security in this report.

11

Calendar No. 1033

95th Congress } SENATE { Report
2d Session } { No. 95–1113

REVOCABILITY OF ELECTION TO RECEIVE RETIRED PAY AS JUDGE OF TAX COURT

August 11 (legislative day, May 17), 1978.—Ordered to be printed

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Mr. Long, from the Committee on Finance, submitted the following

REPORT

[To accompany H.R. 8811]

The Committee on Finance, to which was referred the bill (H.R. 8811) relating to revocability of election to receive retired pay as a judge of the Tax Court, having considered the same, reports favorably thereon without amendment, and recommends that the bill do pass.

I. SUMMARY

The bill allows an individual who has filed an election to receive retired pay as a Tax Court judge to revoke that election at any time before retired pay would begin to accrue, thereby enabling that individual to seek to qualify for benefits under the civil service retirement system (but not under both retirement systems).

II. GENERAL STATEMENT

Present law

If a United States Tax Court judge elects to come under the Tax Court retirement system, all civil service retirement benefits are waived. Thus, any Tax Court judge who elects to be covered by the Tax Court retirement system may not receive any benefits under the civil service retirement system for any service performed before or after the election is made, for services performed as a judge or otherwise.[1]

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[1] A Tax Court judge must retire at age 70, but may retire at age 65 after having served as a judge at least 15 years. A judge may retire at a younger age with 15 years of service if he or she is available for re-appointment at the conclusion of a term but is not reappointed. A judge who is permanently disabled must retire. Generally, retirement under any of these conditions is at full pay under the Tax Court retirement System.

If a judge reaches the mandatory retirement age of 70 before having served 10 years, the Tax Court pension is based on the number of years served. If a judge is retired because of disability, but has not served 10 years, the Tax Court pension is one-half the salary of the office.

No material re social security in this report.

Finder's Aid

P.L. 95-559 (92 Stat. 2131) Approved November 1, 1978
Health Maintenance Organization Amendments of 1978

Subject	SS Act Section	P.L. Section	92 Stat.	H.Rep. 95-1479	S.Rep. 95-837	H.C.Rep. 95-1784
Technical Amendment	1122	14(b)	2141	—	--	--
Technical Amendment	1122(d)(2)	14(b)(3)	2141	4-6, 66	12	23
Anti-Fraud Provision	1902(a)(4)	14(a)(1)	2140	4-6, 66	12	23
Technical Amendment	1903(m)(1)(B)	14(c)	2141	4-6, 66	12	23

11

Public Law 95-559
95th Congress

An Act

To amend the Public Health Service Act to revise and extend the program of assistance under that Act for health maintenance organizations.

Nov. 1, 1978
[S. 2534]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Health Maintenance Organization Amendments of 1978.

SHORT TITLE, REFERENCE TO ACT

SECTION 1. (a) This Act may be cited as the "Health Maintenance Organization Amendments of 1978".

42 USC 201 note.

(b) Whenever in this Act (other than in section 14) an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Public Health Service Act.

42 USC 201 note.

EXTENSION OF PROGRAM

42 USC 300e-3.

SEC. 2. (a) Section 1304(j) is amended (1) by striking out "may be made through September 30, 1978;", and (2) by striking out "1979" and inserting in lieu thereof "1981".

42 USC 300e-4.

(b) Section 1305(d) is amended by striking out "1980" and inserting in lieu thereof "1981".

42 USC 300e-8.

(c) Section 1309(a) is amended (1) by striking out "and" after "1977,", and (2) by striking out the semicolon and all that follows in that section and inserting in lieu thereof the following: ", $31,000,000 for the fiscal year ending September 30, 1979, $65,000,000 for the fiscal year ending September 30, 1980, and $68,000,000 for the fiscal year ending September 30, 1981.".

INITIAL DEVELOPMENT

42 USC 300e-3.

SEC. 3. (a) The first sentence of section 1304(b)(2) is amended by striking out "includes" and inserting in lieu thereof "means the establishment of a health maintenance organization, the expansion of the services of a health maintenance organization, or the".

(b)(1) The first sentence of section 1304(b)(3) is amended by striking out "in the one-year period beginning on" and inserting in lieu thereof "incurred in a period not to exceed three years from".

(2) The second sentence of such section is repealed.

(c)(1) Subparagraph (A) of section 1304(f)(2) is amended to read as follows:

"(A) $1,000,000 through September 30, 1979, and $2,000,000 thereafter, or".

(2) Section 1304(f) is amended—

(A) by striking out "The amount" in paragraph (2) and inserting in lieu thereof "Except as provided in paragraph (3), the amount";

(B) by striking out "(except as provided in paragraph (3))" in paragraph (2); and

(C) by inserting after "(3)" in paragraph (3) the following: "The cumulative total of grants made to, contracts entered into with, and principal of loans guaranteed for, a health maintenance organization under subsection (b) of this section may not exceed $1,000,000 through September 30, 1979, or $2,000,000 thereafter.".

Effective date.
42 USC 300e-3 note.

(d) The amendments made by this section shall only be effective for fiscal years beginning on or after October 1, 1978.

INITIAL OPERATING LOANS AND LOAN GUARANTEES

42 USC 300e-4.

SEC. 4. (a) Section 1305(b)(1) is amended by—

(1) striking out "$2,500,000" and inserting in lieu thereof "$2,500,000 (or $4,000,000 if the Secretary makes a written determination that such loans or loan guarantees are necessary to preserve the fiscally sound operation of the health maintenance organization and to protect against the risk of insolvency of the health maintenance organization and, within 30 days of the making of such loans or loan guarantees, furnishes the Committee on Human Resources of the Senate and the Committee on Interstate and Foreign Commerce of the House of Representatives with written notification of the making of the loans or loan guarantees and a copy of the written determination made with respect to the loans or loan guarantees and the reasons for the determination) through September 30, 1979, and $4,000,000 thereafter"; and

(2) striking out "$1,000,000" and inserting in lieu thereof "$1,000,000 (or $2,000,000 if the Secretary makes a written determination that such disbursements are necessary to preserve the fiscally sound operation of the health maintenance organization and protect against the risk of insolvency of the health maintenance organization and, within 30 days of such disbursement, furnishes the Committee on Human Resources of the Senate and the Committee on Interstate and Foreign Commerce of the House of Representatives with written notification of the making of the disbursement and a copy of the written determination made with respect to it and the reasons for the determination) through September 30, 1979, and $2,000,000 thereafter".

(b)(1) Section 1305(a) is amended by striking out "operating costs" each place it occurs and inserting in lieu thereof "costs of operation".

(2) The second sentence of section 1305(b)(1) is amended by striking out "any fiscal year" and inserting in lieu thereof "any twelve-month period".

(3) The title of section 1305 is amended by striking out "OPERATION COSTS" and inserting in lieu thereof "COSTS OF OPERATION".

42 USC 300e-7.

(c)(1) Section 1308 is amended by adding at the end the following new subsection:

"(f) The Secretary may take such action as he deems appropriate to protect the interest of the United States in the event of a default on a loan made or guaranteed under this title, including taking possession of, holding, and using real property pledged as security for such a loan or loan guarantee.".

(2)(A) Subsection (d) of section 1308 is amended (i) by inserting before the period in the first sentence of paragraph (1) the following: "and to take the action authorized by subsection (f)", and (ii) by inserting after "under this title" in the first sentence of paragraph (2) the following: "and to take the action authorized by subsection (f)".

(B) The first sentence of subsection (e) of section 1308 is amended by inserting before the period the following: "and to take the action authorized by subsection (f)".

(d) The amendments made by this section shall only be effective for fiscal years beginning on or after October 1, 1978.

Effective date.
42 USC 300e4 note.

LOANS AND LOAN GUARANTEES FOR ACQUISITION AND CONSTRUCTION OF AMBULATORY HEALTH CARE FACILITIES

SEC. 5. (a) Title XIII is amended by inserting after section 1305 the following new section:

42 USC 300e.

"LOANS AND LOAN GUARANTEES FOR ACQUISITION AND CONSTRUCTION OF AMBULATORY HEALTH CARE FACILITIES

"SEC. 1305A. (a) The Secretary may—

"(1) make loans, from the fund established under section 1308 (e), to public and nonprofit private health maintenance organizations for projects for the acquisition or construction of ambulatory health care facilities and for the acquisition of equipment for facilities acquired or constructed under a loan made under this paragraph; and

42 USC 300e–4a.
42 USC 300e–7.

"(2) guarantee to—

"(A) non-Federal lenders for their loans to nonprofit private health maintenance organizations for projects described in paragraph (1) and to private health maintenance organizations for such projects which will serve medically underserved populations, and

"(B) the Federal Financing Bank for its loans to nonprofit private health maintenance organizations for projects described in paragraph (1) and to private health maintenance organizations for such projects which will serve medically underserved populations,

the payment of principal and interest on such loans.

"(b)(1) Except as provided in paragraph (2), the aggregate amount of principal of loans made or guaranteed, or both, under subsection (a) for an ambulatory health care facility may not exceed $2,500,000.

Principal of loans, limitation.

"(2) The cumulative total of the principal of the loans outstanding at any time which have been directly made or with respect to which guarantees have been issued under subsection (a) may not exceed such limitations as may be specified in appropriation Acts.

Cumulative total, limitation.

"(3) The authority of the Secretary to make loans under subsection (a) shall be effective for any fiscal year only to such extent or in such amounts as are provided in advance in appropriation Acts.

"(c) For purposes of this section—

"(1) The term 'ambulatory health care facility' means a health care facility for the provision of diagnostic, treatment, and prevention services to ambulatory patients; and

"Ambulatory health care facility."

"(2) the term 'construction' means the (A) construction of new facilities, (B) alterations, expansion, remodeling, replacement, and renovation of existing facilities, (C) cost of offsite improvements in connection with an activity described in clause (A) or (B), and (D) cost of the acquisition of land in connection with an activity described in clause (A), (B), or (C).".

"Construction."

(b) Section 1313(4) is amended by inserting before the period the following: "or in meeting the costs of such organizations in acquiring or constructing ambulatory health care facilities".

42 USC 300e–12.

CONTINUING DEVELOPMENT ASSISTANCE

42 USC 300e-3.

SEC. 6. Section 1304(b) is amended by adding after parag
the following new paragraph:

42 USC 300e-9.

"(4) A health maintenance organization which is a qualifie
maintenance organization within the meaning of section 1310
receive, in accordance with paragraph (1), a grant, contract,
guarantee for the expansion of its services or the significant ex
of its membership or the area served by it.".

TRAINING AND TECHNICAL ASSISTANCE

42 USC 300e.

SEC. 7. (a) Title XIII is amended by adding at the end the
following new section:

"TRAINING AND TECHNICAL ASSISTANCE

National Health Maintenance Organization Intern Program. Establishment. 42 USC 300e-16.

"SEC. 1317. (a)(1) The Secretary shall establish a National
Maintenance Organization Intern Program (hereinafter in th
section referred to as the 'Program') for the purpose of pro
training to individuals to become administrators and medical
tors of health maintenance organizations or to assume other man
positions with health maintenance organizations. Under the Pr
the Secretary may directly provide internships for such trainin
may make grants to or enter into contracts with health mainte
organizations and other entities to provide such internships.

"(2) No internship may be provided by the Secretary and no
may be made or contract entered into by the Secretary for the
vision of internships unless an application therefor has been
mitted to and approved by the Secretary. Such an application
be in such form and contain such information, and be submitt
the Secretary in such manner, as the Secretary shall prescribe.
tion 1306 does not apply to an application submitted under this sec

Travel and other expenses. Payments to organization or othere entity.

"(3) Internships under the Program shall provide for such stip
and allowances (including travel and subsistence expenses
dependency allowances) for the recipients of the internships as
Secretary deems necessary. An internship provided an individual
training at a health maintenance organization or any other entity s
also provide for payments to be made to the organization or o
entity for the cost of support services (including the cost of sala
supplies, equipment, and related items) provided such individual
such organization or other entity. The amount of any such payme
to any organization or other entity shall be determined by the Sec
tary and shall bear a direct relationship to the reasonable costs of
organization or other entity for establishing and maintaining its tra
ing programs.

"(4) Payments under grants under the Program may be made
advance or by way of reimbursement, and at such intervals and
such conditions, as the Secretary finds necessary.

Technical assistance. 42 USC 300e-2, 300e-3. 42 USC 300e-9.

"(b) The Secretary shall provide technical assistance (1)
entities in connection with projects for which assistance is being pr
vided under section 1303 or 1304, (2) to entities intending to becom
a qualified health maintenance organization within the meaning o
section 1310(d), and (3) to health maintenance organizations. Th
Secretary may provide such technical assistance through grants t
public and nonprofit private entities and contracts with public an
private entities.

"(c) The authority of the Secretary to enter into contracts under subsections (a) and (b) shall be effective for any fiscal year only to such extent or in such amounts as are provided in advance by appropriation Acts.".

(b) Section 1309(a) is amended by striking out "and 1304(b)" and inserting in lieu thereof "1304(b), and 1317".

42 USC 300e-8.
Ante p. 2134.

(c) The amendments made by this section shall only be effective for fiscal years beginning on or after October 1, 1978.

42 USC 300e-16 note.

EMPLOYEE HEALTH BENEFIT PLANS

SEC. 8. (a) Section 1310(c) is amended by adding at the end the following: "Each employer which provides payroll deductions as a means of paying employees' contributions for health benefits or which provides a health benefits plan to which an employee contribution is not required and which is required by subsection (a) to offer his employees the option of membership in a qualified health maintenance organization shall, with the consent of an employee who exercises such option, arrange for the employee's contribution for such membership to be paid through payroll deductions.".

42 USC 300e-9.

(b) Clauses (1) and (2) of section 1310(b) are amended to read as follows:

"(1) one or more of such organizations provides basic health services through physicians or other health professionals who are members of the staff of the organization or a medical group (or groups), and

"(2) one or more of such organizations provides basic health services through (A) an individual practice association (or associations), or (B) a combination of such association (or associations), medical group (or groups), staff, and individual physicians and other health professionals under contract with the organization,".

FINANCIAL DISCLOSURE; ENROLLMENT PROTECTION

SEC. 9. (a) Title XIII as amended by section 7 is amended by adding at the end the following new section:

42 USC 300e.

"FINANCIAL DISCLOSURE

"SEC. 1318. (a) Each health maintenance organization shall, in accordance with regulations of the Secretary, report to the Secretary financial information which shall include the following:

42 USC 300e-17.

"(1) Such information as the Secretary may require demonstrating that the health maintenance organization has a fiscally sound operation.

"(2) The information required to be reported under section 1124 of the Social Security Act by disclosing entities and the information required to be supplied under section 1902(a)(38) of such Act.

42 USC 1320a-3.

42 USC 1396a.

"(3) A description of transactions, as specified by the Secretary, between the health maintenance organization and a party in interest. Such transactions shall include—

"(A) any sale or exchange, or leasing of any property between the health maintenance organization and a party in interest;

"(B) any furnishing for consideration of goods, services (including management services, but excluding health services provided to members by staff, medical group (or groups), individual practice association (or associations), or any combination thereof), or facilities between the health maintenance organization and a party in interest; and

"(C) any lending of money or other extension of credit between a health maintenance organization and a party in interest.

Consolidated financial statement.

The Secretary may require that information reported respecting a health maintenance organization which controls, is controlled by, or is under common control with, another entity be in the form of a consolidated financial statement for the organization and such entity.

"Party in interest."

"(b) For the purposes of this section the term 'party in interest' means:

"(1) any director, officer, partner, or employee of a health maintenance organization, any person who is directly or indirectly the beneficial owner of more than 5 per centum of the equity of the organization, any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than 5 per centum of the health maintenance organization, and, in the case of a health maintenance organization organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law;

"(2) any entity in which a person described in paragraph (1)—

"(A) is an officer or director;

"(B) is a partner (if such entity is organized as a partnership);

"(C) has directly or indirectly a beneficial interest of more than 5 per centum of the equity; or

"(D) has a mortgage, deed of trust, note, on other interest valuing more than 5 per centum of the assets of such entity;

"(3) any person directly or indirectly controlling, controlled by, or under common control with a health maintenance organization; and

"(4) any member of the immediate family of an individual described in paragraph (1).

Information, availability.

"(c) Each health maintenance organization shall make the information reported pursuant to subsection (a) available to its enrollees upon reasonable request.

Evaluation of transactions.

"(d) The Secretary shall, as he deems necessary, conduct an evaluation of transactions reported to the Secretary under subsection (a)(3) for the purpose of determining their adverse impact, if any, on the fiscal soundness and reasonableness of charges to the health maintenance organization with respect to which they transpired.

Number of organizations.

The Secretary shall evaluate the reported transactions of not less than five, or if there are more than twenty health maintenance organizations reporting such transactions, not less than one-fourth of the health maintenance organizations reporting any such transactions under subsection (a)(3).

Report to Congress.

"(e) The Secretary shall file an annual report with the Congress on the operation of this section. Such report shall include—

"(1) an enumeration of standards and norms utilized to make the evaluations required under subsection (d);

Conformity, or nonconformity.

"(2) an assessment of the degree of conformity or nonconformity of each health maintenance organization evaluated by the Secretary under subsection (d) with such standards and norms;

"(3) what action, if any, the Secretary considers necessary under section 1312 with respect to health maintenance organizations evaluated under subsection (d).

42 USC 300e-11.

Rates.

"(f) Nothing in this section shall be construed to confer upon the Secretary any authority to approve or disapprove the rates charged by any health maintenance organization.

Annual financial statement, filing.

"(g) Any health maintenance organization failing to file with the Secretary the annual financial statement required in subsection (a) shall be ineligible for any Federal assistance under this title until such time as such statement is received by the Secretary and shall not be a qualified health maintenance organization for purposes of section 1310.

42 USC 300e-9.

False statement or representation of material fact, penalty.

"(h) Whoever knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any statement filed pursuant to this section shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.".

42 USC 300e.

(b) Section 1301(c)(3) is amended (1) by inserting "(A)" after "(3)", and (2) by inserting before the semicolon a comma and the following: "and (B) carry out enrollment of members who are entitled to medical assistance under a State plan approved under title XIX of the Social Security Act in accordance with procedures approved under regulations promulgated by the Secretary".

42 USC 1396.

ORGANIZATION REQUIREMENTS

42 USC 300e.

SEC. 10. (a) Section 1301(b) is amended (1) by inserting "except in the case of basic health services provided a member who is a full-time student (as defined by the Secretary) at an accredited institution of higher education," after "(C)" in paragraph (1), and (2) by inserting "unless the supplemental health services payment is for a supplemental health service provided a member who is a full-time student (as defined by the Secretary) at an accredited institution of higher education," after "community rating system" in the second sentence of paragraph (2).

(b) Section 1301(c)(1) is amended (1) by inserting "(A)" after "(1)", and (2) by inserting before the semicolon a comma and the following: "and (B) have administrative and managerial arrangements satisfactory to the Secretary".

(c) Section 1301(c)(6) is amended (1) by striking out "(6)" and inserting in lieu thereof "(6)(A) in the case of a private health maintenance organization,", (2) by redesignating clauses (A) and (B) as subclauses (i) and (ii), respectively, and (3) by inserting before the semicolon a comma and the following: "and (B) in the case of a public health maintenance organization, have an advisory board to the policymaking body of the public entity operating the organization which board meets the requirements of clause (A) of this paragraph and to which may be delegated policymaking authority for the organization."

REQUIREMENTS FOR THE PROVISION OF SERVICES

42 USC 300e.

SEC. 11. (a) Paragraph (3) of section 1310(b) is amended to read as follows:

"(3)(A) Except as provided in subparagraph (B), the services of a physician which are provided as basic health services shall be provided through—

"(i) members of the staff of the health maintenance organization,

"(ii) a medical group (or groups),

"(iii) an individual practice association (or associations),

"(iv) subject to subparagraph (C), physicians or other health professionals who have contracted with the health maintenance organization for the provision of such services, or

"(v) any combination of such staff, medical group (or groups), individual practice association (or associations) or physicians or other health professionals under contract with the organization.

"(B)(i) Subparagraph (A) does not apply to the provision of the services of a physician—

"(I) which the health maintenance organization determines, in conformity with regulations of the Secretary, are unusual or infrequently used, or

"(II) which are provided a member of the organization in a manner other than that prescribed by subparagraph (A) because of an emergency which made it medically necessary that the service be provided to the member before it could be provided in a manner prescribed by subparagraph (A).

42 USC 300e-2.

"(ii) In a forty-eight-month period beginning after the month in which a health maintenance organization becomes a qualified health maintenance organization (within the meaning of section 1310(d)), the organization may provide the services of physicians through an entity which but for the requirement of section 1302(4)(C)(i) would be a medical group for the purposes of this title. After the expiration of such period, the organization may provide physician services through such an entity only if authorized by the Secretary in accordance with regulations which take into consideration the unusual circumstances of such entity.

Contracts with other than staff physicians, prohibition.

"(C) After the expiration of the first four fiscal years of a health maintenance organization beginning after the month in which it became a qualified health maintenance organization (within the meaning of section 1310(d)), the organization may not enter into contracts with physicians other than members of staff, medical groups, or individual practice associations if the amounts paid under such contracts for basic and supplemental health services provided by physicians exceed 15 per centum of the total estimated amount to be paid in such fiscal year by the health maintenance organization to physicians for the provision of basic and supplemental health services by physicians, or, if the health maintenance organization principally serves a rural area, 30 per centum of such amount, except that this subparagraph does not apply to the entering into contracts for the purchase of physician services through an entity which, but for the requirements of section 1302(4)(C)(i), would be a medical group for the purposes of this title.

42 USC 300e-2.

"(D) Contracts between a health maintenance organization and health professionals for the provision of basic and supplemental health services shall include such provisions as the Secretary may require (including provisions requiring appropriate continuing education).

"Health professional."

"(E) For purposes of this paragraph the term 'health professional' means physicians, dentists, nurses, podiatrists, optometrists, and such other individuals engaged in the delivery of health services as the Secretary may by regulation designate.".

42 USC 300e. Basic health service payment.

(b) Section 1301(b)(1) is amended by adding at the end the following: "The requirements of this paragraph respecting the basic health services payment shall not apply to the provision of basic health services to a member for an illness or injury for which the member is entitled to benefits under a workmen's compensation law or an insurance policy but only to the extent such benefits apply to such services. For the provision of such services for an illness or injury for which a member is entitled to benefits under such a law, the health maintenance organization may, if authorized by such law, charge or authorize the provider of such services to charge, in accordance with the charges allowed under such law, the insurance carrier, employer, or other entity which under such law is to pay for the provision of such services or, to the extent that such member has been paid under such law for such services, such member. For the provision of such services for an illness or injury for which a member is entitled to benefits under an insurance policy, a health maintenance organization may charge or authorize the provider of such services to charge the insurance carrier under such policy or, to the extent that such member has been paid under such policy for such services, such member.".

Charges by health maintenance organization or provider of services.

Reimbursement.

(c) The second sentence of section 1301(b)(4) is amended to read as follows: "A member of a health maintenance organization shall be reimbursed by the organization for his expenses in securing basic and supplemental health services other than through the organization if the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition.".

(d) Section 1301(b) is amended by adding at the end the following new paragraph:

Natural disaster, war, riot, or other similar event.

"(5) To the extent that a natural disaster, war, riot, civil insurrection, or any other similar event not within the control of a health maintenance organization (as determined under regulations of the Secretary) results in the facilities, personnel, or financial resources of a health maintenance organization not being available to provide or arrange for the provision of a basic or supplemental health service in accordance with the requirements of paragraphs (1) through (4) of this subsection, such requirements only require the organization to make a good-faith effort to provide or arrange for the provision of such service within such limitation on its facilities, personnel, or resources.".

42 USC 300e-1.

(e) Section 1302(1) is amended by inserting before the second sentence the following: "Such term does not include a health service which the Secretary, upon application of a health maintenance organization, determines is unusual and infrequently provided and not neces-

Publication in Federal Register.

sary for the protection of individual health. The Secretary shall publish in the Federal Register each determination made by him under the preceding sentence.".

ADMINISTRATION OF PROGRAM

Repeal. 42 USC 300e-9. Repeal. 42 USC 300e-11. 42 USC 300e-5.

SEC. 12. (a)(1) Subsection (h) of section 1310 is repealed.

(2) Subsection (c) of section 1312 is repealed.

(b) Section 1306(b)(2) is amended by inserting "in the case of an application for assistance under section 1304, 1305, or 1305A," before "he determines".

(c) Section 1306(b) is amended by adding at the end the following new sentence: "In determining, for purposes of paragraph (2), whether an applicant would be able to complete a project or undertaking without the assistance applied for, the Secretary shall not consider any asset of the applicant the obligation of which for such undertaking or project would jeopardize the fiscal soundness of the applicant.".

PROGRAM MANAGEMENT EVALUATION

42 USC 300e-13. Grant and loan programs. Report to Congress.

SEC. 13. Section 1314 is amended by adding at the end thereof the following new subsection:

"(d) The Comptroller General shall evaluate the adequacy and effectiveness of the policies and procedures of the Secretary for the management of the grant and loan programs established by this title and the adequacy of the amounts of assistance available under such programs and shall report to the Congress the results of such evaluation not later than May 1, 1979.".

AMENDMENTS TO THE SOCIAL SECURITY ACT

42 USC 1396a.

SEC. 14. (a)(1) Section 1902(a)(4) of the Social Security Act is amended (A) by striking out "and" at the end of clause (A), and (B) by inserting before the semicolon a comma and the following: "and (C) that each State or local officer or employee who is responsible for the expenditure of substantial amounts of funds under the State plan, each individual who formerly was such an officer or employee, and each partner of such an officer or employee shall be prohibited from committing any act, in relation to any activity under the plan, the commission of which, in connection with any activity concerning the United States Government, by an officer or employee of the United States Government, an individual who was such an officer or employee, or a partner of such an officer or employee is prohibited by section 207 or 208 of title 18, United States Code".

Effective date. 42 USC 1396a. Note.

(2)(A) Except as provided in subparagraph (B), the amendments made by paragraph (1) shall take effect one hundred and eighty days after the date of the enactment of this Act.

42 USC 1396.

(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary determines requires State legislation in order for the plan to meet the requirement added by the amendments made by paragraph (1), such amendments shall not apply with respect to such State plan before ninety days after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act.

(b) Section 1122 of the Social Security Act is amended— 42 USC 1320a-1.

(1) by striking out "or health maintenance organizations" each place it occurs,

(2) by striking out "or health maintenance organizations" each place it occurs, and

(3) by striking out "or organization, or of any facility of such organization," in subsection (d)(2).

(c) Section 1903(m)(1)(B) of the Social Security Act is amended by striking out "shall be administered through the Assistant Secretary for Health and in the Office of the Assistant Secretary for Health, and the administration of such duties and functions". 42 USC 1396b.

Approved November 1, 1978.

LEGISLATIVE HISTORY:

HOUSE REPORTS: No. 95-1479 accompanying H.R. 13655 (Comm. on Interstate and Foreign Commerce) and No. 95-1784 (Comm. of Conference).
SENATE REPORT No. 95-837 (Comm. on Human Resources).
CONGRESSIONAL RECORD, Vol. 124 (1978):
July 21, considered and passed Senate.
Sept. 25, H.R. 13655 considered and passed House; passage vacated and S. 2534, amended, passed in lieu.
Oct. 13, House agreed to conference report.
Oct. 14, Senate agreed to conference report.

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[illegible]

95th Congress } HOUSE OF REPRESENTATIVES { Report
2d Session } { No. 95-1479

HEALTH MAINTENANCE ORGANIZATION AMENDMENTS OF 1978

REPORT

BY THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

together with

SEPARATE AND DISSENTING VIEWS

[To accompany H.R. 13655]

[And Including Cost Estimate of the Congressional Budget Office]

August 11, 1978.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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introduced on June 22, 1978 by Mr. Rogers, Chairman of the Subcommittee on Health and the Environment. Hearings were conducted on H.R. 13266 and all similar or identical bills on June 30, 1978. At that time, testimony was received from the following witnesses:

I. Hale Champion, Under Secretary, Department of Health, Education and Welfare

II. Gregory A. Ahart, Director, Human Resources Division, General Accounting Office

III. A panel consisting of: Thomas J. Ernst, Vice President, St. Louis Metro Health Plan, St. Louis, Missouri. Roger W. Birnbaum, Executive Director, Rutgers Community Health Plan, New Brunswick, New Jersey

IV. A panel consisting of: James Roberts, M.D., Medical Director, Genesee Valley Group Health Association, Rochester, New York. Larry Hoffheimer, American Group Practice Association. W. Palmer Dearing, M.D., Medical Consultant, Blue Cross Association. William G. Kopit, American Association of Foundations for Medical Care. Calvin Johnson, Health Insurance Association of America. Roger Graham, Assistant Vice President for Professional Affairs, National Association for Blue Shield Plans. John G. Smillie, M.D., Permanente Medical Group, Kaiser Foundation Health Plan.

The bill was subsequently considered in open executive sessions by the Subcommittee on Health and the Environment, amended, reported and reintroduced as a clean bill, H.R. 13655, on July 22, 1978, by Rogers and eleven other members of the Subcommittee.

H.R. 13655 was considered by the Interstate and Foreign Commerce Committee on August 8, 1978, amended and ordered reported by a vote of 17 to 5.

II. SUMMARY OF LEGISLATION

The purpose of this legislation is to amend and extend Title XIII of the Public Health Service Act which provides a program of assistance for health maintenance organizations (HMO's). This title was established by Public Law 93–222, the "Health Maintenance Organization Act of 1973."

As approved by the Committee, H.R. 13655 would amend existing law in the manner described below.

(1) It would extend the authorizations of appropriations for making grants and contracts to support entities desiring to become HMO's and HMO's for two fiscal years. Sixty-three million dollars would be authorized in both FY 1980 and FY 1981.

(2) The requirements related to an HMO's provision of services would be modified. The HMO would be allowed to collect payments from a workmen's compensation or insurance program for services covered by those programs. The restrictions on an HMO's ability to contract for physicians' services would be reduced during the HMO's first four years. An HMO would not be required to assume financial responsibility for services provided by another organization if the member intentionally left the area served by the HMO. Provisions would be added to modify the requirements that HMO's provide basic health services in the case of a disaster or similar occurrence or in the

case where a service is unusual or infrequently performed and not necessary to protect the health of the individual.

(3) It would modify certain HMO organizational requirements including allowing an HMO to experience rate student members, requiring an HMO to have certain administrative and managerial arrangements and capabilities, authorizing the Secretary to establish rules for the enrollment of medicaid beneficiaries, and modifying the policy-making body requirements for public HMO's.

(4) The authority for grants and loan guarantees for initial development would be amended to allow an HMO to be eligible for its establishment and up to $600,000 to support each significant expansion of membership or areas served; and amend the authority for grant support for HMO feasibility studies to allow grants regardless of the financial position of the applicant.

(5) It would expand the loan and loan guarantee support that may be provided to an HMO for its initial costs of operation from $2.5 to $4.0 million or, in any one year from $1 million to $2 million; and extend authority for this loan and loan guarantee support through September 30, 1981.

(6) Each employer which provides payroll deductions as a means of paying employees contributions for health benefits or which provides employees a health benefits plan would be required to payroll deduct the employees' contribution to the HMO upon the request of the employee.

(7) It would allow funds under section 319, "Migrant Health" and section 330, "Community Health Centers," of the Public Health Service Act to be used for grants for the planning and development of health services to be provided on a prepaid basis, or for the provision of health services on a prepaid basis.

(8) A program of loan and loan guarantee support for the acquisition and construction of ambulatory health care facilities would be established. Support would be limited to $2.5 million.

(9) It would establish a program of technical assistance and a National Health Maintenance Organization Intern Program for the purpose of training individuals to become administrators and medical directors of HMO's.

(10) The requirement that the qualification and compliance function be located in the Office of the Assistant Secretary for Health would be deleted.

(11) It would require that all qualified HMO's must provide the Secretary with ownership information and with related information to demonstrate that the HMO is fiscally sound and to allow for the examination of transactions between the HMO and a party in interest.

(12) It would extend to state and local officers or employees who are responsible for the expenditure of substantial amounts of Medicaid funds the conflict-of-interest provisions which apply to Federal officers or employees.

(13) The capital expenditure review provisions of the Social Security Act (section 1122) would be amended to provide that HMO's be covered equally with other health care institutions.

(14) Finally, it would authorize the Secretary to waive the policy-making body composition requirements of Title XIII for certain

HMO's which are part of an insurance company or Blue Cross plan and were in operation as of July 1, 1978. Eligible HMO's would have one and one half years to apply for qualification under the amendment. The Secretary may impose such terms and conditions on the HMO as he deems appropriate; and in areas served by an HMO which receives a waiver the employers may be required to offer two HMO's of the same type as that HMO which received the waiver.

III. Cost of the Legislation

As reported by the Committee, H.R. 13655 provides authorizations of appropriations of $63 million for both fiscal years 1980 and 1981.

H.R. 12460, the "Health Centers Amendments of 1978" reported by the Committee on Interstate and Foreign Commerce on May 15, 1978 includes authorizations of appropriations for Title XIII of the Public Health Service Act for grants and contracts for feasibility surveys, planning, and initial development costs of $45 million in fiscal year 1979, and for grants and contracts for initial development costs of $50 million in fiscal year 1980. It is the Committee's intent during debate on this measure by the House of Representatives to amend H.R. 12460 to reduce the authorizations of appropriations to $25 million for fiscal year 1979. Authorization of loan guarantee support is extended through September 30, 1979.

This can be compared with the recent budget history of Title XIII:

[In millions of dollars]

Authorizations (fiscal year):	
1974	25.0
1975	55.0
1976	40.0
1977	45.0
1978	45.0
Approoriations (fiscal year):	
1974	25.0
1975	15.0
1976	19.0
1977	18.1
1978	22.1

The Committee has adopted the authorization levels for the next three fiscal years based upon the following HMO activity projected by the Department of Health, Education, and Welfare.

PROJECTED HMO ACTIVITY

[Dollar amounts in thousands]

Grants	Number of grants, 1979	Amount	Number of grants, 1980	Amount	Number of grants, 1981	Amount
Feasibility	70	$5,250	64	$4,800	64	$4,800
Planning	53	10,600	53	10,600	48	9,600
Initial development	5	4,000	48	38,400	48	38,400
Expansion	5	2,500	10	5,000	10	5,000
Technical assistance/training		2,000		4,000		4,000
Total		24,350		62,800		61,800

Assumptions: Feasibility grants will be funded at an average of $75,000—75 percent of these projects will go onto planning stage; planning grants will be funded at an average of $200,000—90 percent of these projects, will go onto initial development; initial development grants will be funded at an average of $800,000—95 percent of these projects will become operational; expansion grants will be funded at an average of $500,000.

Source: Office of Health Maintenance Organization, DHEW.

ship and control, for instance, might be filed upon application for qualification and subsequently upon any change in its ownership and control relationships, while information regarding transactions with parties in interest might be required to be available upon HEW's request without any requirement of annual filing. The Committee has left the appropriateness of the filing requirements to be determined by the Secretary so that each reporting requirement can be tailored to take action against activities by the management of or parties in interest in the HMO which adversely affect the HMO. In making such determinations, the Secretary should balance the burden which such requirements place on HMO's against the usefulness of the data collected.

The Secretary is required to include in the annual report (required by section 1315) a summary of analyses of the information provided pursuant to these reporting requirements and a description of any action taken as a result of such evaluations.

Amendments to the Social Security Act (Section 13)

Conflict of interest

The Committee's bill includes two amendments to the Social Security Act. The first deals with the activities of State and local officers and employees who are responsible for the expenditure of substantial amounts of funds under the State Medicaid program.

The Committee believes that sections 207 and 208 of Title 18 of the United States Code, provide reasonable restrictions on the activities of current and former officers and employees of the executive branch of the United States Government in order to prevent conflicts of interest on the part of those officers and employees. These restrictions protect the interest of the United States Government as well as the integrity of the Agency or program for which the officers or employees work. The Committee's proposal amends title 19 of the Social Security Act to extend these restrictions to (1) State and local officers and employees who are responsible for the expenditure of substantial amounts of funds under the State medicaid plan (2) to each individual who formerly was such an officer or employee and (3) to each partner of such an officer or employee. By extending these restrictions to these State and local officers and employees, the Committee believes that the interest of State and local governments and the integrity of the State Medicaid plans will be protected against conflicts of interest on the part of those State officers and employees.

Section 207 prohibits any former officer or employee of the executive branch of the Federal government from (1) acting as agent or attorney for anyone other than the United States in matters connected with their former duties or official responsibilities in which such person participated personally and substantially, or (2) appearing personally before any court or Federal government agency as agent or attorney for one year for anyone other than the United States in connection with any matter which was under such person's official responsibility within one year prior to terminating such responsibility. Section 207 also prohibits any partner of an officer or employee from acting as agent or attorney for anyone other than the United States in matters in which such officer or employee participates or has participated or which are the subject of his official responsibility. Section 208 prohibits an officer or employee of the United States from participating in matters in which he, his family, partner or any organization with which he is associated has a financial interest.

REVIEW OF CAPITAL EXPENDITURES

The reported bill amends section 1122 of the Social Security Act, which deals with the review of proposed capital expenditures by planning agencies and subsequent reimbursement by the medicaid and medicare program. The amendment would require that HMO's be covered equally with other health care entities or organizations under this review program. Under current law, an HMO is subject to requirements which could promote discrimination against HMO's. Specifically, the establishment of an HMO and its development of outpatient facilities and services currently are required to be covered, while similar noninstitutional services are not. The reported bill seeks to eliminate this discrepancy.

EMPLOYEES' HEALTH BENEFIT PLANS (SECTION 14)

The Committee has been encouraged by the active involvement of Blue Cross/Blue Shield and commercial insurance carriers in the support and development of HMO-like plans. The Committee is also pleased with the commitment which these organizations have made to continue that activity and augment Federal HMO developmental efforts. However, the Committee was advised by Blue Cross/Blue Shield that many of its plans have been operating various alternative health care delivery systems for several years—which they developed with their own resources and managerial talents—but which cannot be qualified as health maintenance organizations primarily because of the provisions of section 1301(c)(6) requiring that one-third of the governing board be composed of HMO members. These alternative delivery systems are operated as a line of business of the Blue Cross/Blue Shield plans, rather than through a separate legal entity, and are subject to the overall supervision and control of the Blue Cross/Blue Shield Board of Directors.

A provision is included in the bill which would deal with this problem by granting the Secretary discretionary authority to waive the provisions of section 1301(c)(6) for commercial insurance carriers or nonprofit carriers which provide hospital service benefits or medical or surgical benefits, or both, and which on July 1, 1978 were operating an HMO as defined in regulations developed pursuant to section 1122 of the Social Security Act). In all other respects, the plan would be required to meet the organization, operational and other requirements of Title XIII. The waiver would be granted only on such terms and conditions as the Secretary may determine are appropriate. Among other requirements, these may include controls and assurances such as: the right of the HMO's management to develop or arrange for independent marketing efforts and/or to enroll members directly and not exclusively through Blue Cross/Blue Shield; assurances that dual choice provisions of the HMO Act will not be used to market other lines of business; separate accounting for the HMO line of business and other controls designed to assure accountability and as competitive a premium structure as possible; to the extent permitted by state tions to choose the remaining third without mandating at least this minimal representation of enrollees who are to be served by the HMO and who ought to have the opportunity to raise issues of special concern. Relegating them to an advisory board only is insufficient.

Blue Cross governing boards appear to be controlled by hospital administrators; while Blue Shield boards are controlled by physicians. Thirty-six of the sixty-nine Blue Shield governing boards have physician majorities. The number grows to forty-four when hospital administrators are counted to form "provider majorities." Most plans also have a majority of physicians on their fee setting and review committees or the committees are completely composed of physicians. It seems inconsistent with the intent of the HMO legislation to allow these groups to receive waivers.

It has been argued that the one-third consumer representation requirement is particularly difficult for Blue Cross/Blue Shield. But no explanation of why this is so has been put forward. It should be noted that this amendment only allows plans that came into existence prior to July 1, 1978 (of which there are fourteen) to apply for a waiver. Any new plan must meet the requirements of existing law. This strongly suggests that the problems to which they allude are not serious. It simply grandfathers existing plans, a majority of which were started after the passage of the HMO Act of 1973 full cognizance of the requirements of the law.

Why is the Congress being asked to waive one of the few requirements that assures at least minimal public accountability of existing HMOs? As the Health Insurance Association of America, representing over 300 insurance companies, is strenuously opposing this amendment, we can assume that only Blue Cross/Blue Shield would like our support for provider domination and the reduction of competition it would produce.

In conclusion, we submit that the proponents of Section 14 of the HMO Amendments of 1978 have shown no justification for its inclusion in the bill. To the contrary, all the evidence that we have seen demonstrates a fundamental need for increased consumer representation to assure greater public accountability. We hope you will join with us in opposing this special interest provision.

John D. Dingell.
Albert Gore, Jr.
Marc L. Marks.
John E. Moss.
Henry A. Waxman.

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Calendar No. 768

95th Congress
2d Session

SENATE

Report
No. 95–837

HEALTH MAINTENANCE ORGANIZATION ACT AMENDMENTS OF 1978

May 15 (legislative day, April 24), 1978.—Ordered to be printed

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Mr. Kennedy, from the Committee on Human Resources, submitted the following

REPORT

[To accompany S. 2534]

The Committee on Human Resources, to which was referred the bill to revise and extend the provisions of Title XIII of the Public Health Service Act relating to health maintenance organizations, having considered the same, reports favorably thereon with an amendment (in the nature of a substitute), and recommends that the bill as amended do pass.

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X. S. 2534, as amended by the Committee on Human Resources — 36

I. Summary of S. 2534

As approved by the Committee, S. 2534 would—

(1) Extend the authorizations of appropriations for HMO feasibility, planning, and initial development grants and contracts for five fiscal years. For FY 1979, the legislation would authorize for these purposes $50 million; for FY 1980, $70 million; for FY 1981, $90 million; for 1982, $95 million; and for FY 1983, $95 million. In addition, the legislation would authorize to be appropriated an additional $95 million in FY 1984 for initial development grants and contracts.

intended that individual HMOs or other entities receive assistance for the purpose of establishing or subsidizing formal academic degree programs.

The Committee expects that the training program will incorporate and reflect the broad spectrum of legitimate organizational and operational techniques present throughout the HMO community. In addition, the Department should carefully establish an appropriate balance of field and classroom training.

G. FINANCIAL DISCLOSURE

Since certain serious abuses of the HMO concept were brought to light in 1975, the Committee has been seriously concerned that such isolated examples of health care profiteering could jeopardize the viability of the HMO concept. The 1976 HMO amendments contained provisions directly aimed at the kinds of abuses first reported in 1975, requiring that any HMO receiving Medicare or Medicaid monies be federally-qualified.

The Committee is pleased to note the continued attention of other Committees of the Congress to the problems of fraud and abuse in health care and particularly the extensive work done by the Governmental Affairs Committee in isolating the abuses which occurred in California in the early 1970s. Since information on these incidents has been available to the Committee for some time, they were the subject of extensive study and careful analysis in the drafting of S. 2534.

The Committee has devoted a great deal of time and effort to developing anti-fraud and abuse provisions which, in concert with those contained in the 1976 amendments, would be aimed at preventing abuses of the program without stifling the development of a promising health care reform. Section 10 of S. 2534 was drafted in close cooperation with the General Accounting Office and the Department of Health, Education and Welfare. and was supported by GAO witnesses in testimony before the Subcommittee on Health and Scientific Research. Rather than simply *prohibit* certain classes of transactions, section 10 requires disclosure of suspect, or potentially abusive, transactions and evaluation of those transactions by HEW. Despite extensive study, the Committee was unable to isolate clearly definable categories of transactions which were so consistently abusive or fraudulent as to warrant outright prohibition. Indeed, transactions with related organizations may, in certain situations, result in economic efficiencies that are beneficial to the HMO and its enrollees, rather than fraudulent or abusive. The Committee believes that the nature of the fraud and abuse problem in the highly variable and still-experimental HMO arena requires a careful screening of potential conflicts of interest for their *adverse affect* on HMOs, rather than categorical prohibitions or detailed requirements for HMO management.

The Committee intends to follow the development of HEW's new compliance program in detail. The record of hearings on S. 2534 before the Subcommittee on Health and Scientific Research documents the extensive time devoted to the fraud and abuse issue in testimony by HEW and the General Accounting Office, and subsequent questioning by the members of the Subcommittee. The Committee expects HEW to develop strong and aggressive compliance procedures under its announced reorganization plan.

In addition, the Committee hopes the Department will be aware of and sensitive to the greatly increased paperwork burdens inevitably resulting from the new disclosure provisions and will make every effort to limit those burdens, to the extent effective administration of the program allows.

H. HEALTH PLANNING AMENDMENTS

Under existing provisions of the Health Planning Act, health maintenance organizations are subject to certificate-of-need requirements for virtually all phases of their operation. The activities of fee-for-service physicians, on the other hand, are seldom covered by CON laws.

The Committee views with great concern a growing body of evidence that the planning process has seriously handicapped HMO development. Among the original purposes of the Health Planning Act was the encouragement of cost containment in the fee-for-service system through more efficient allocation and management of health care resources. In contrast to the fee-for-service system, health maintenance organizations contain internal cost containment incentives and have proved their ability to reduce health care costs. Despite this exceptional capacity to serve the overall goals of the planning process when allowed to operate properly, testimony before the Committee revealed repeated instances of misunderstanding of the HMO concept and discrimination against HMO certificate-of-need applications at the HSA and State Agency levels. This evidence indicates that HMOs, because they compete with the fee-for-service system, are frequently given unobjective appraisals of CON applications by provider-dominated HSAs. This situation is particularly serious since HMOs are usually new entrants into an area and do not enjoy the presumptions benefiting the status quo under the planning process.

While it was clear to the Committee that this situation required remedy, the members were concerned that the exemptions from CON contained in the original version of S. 2534 might intrude upon legitimate state prerogatives and give HMOs too great an advantage over fee-for-service physicians. Section 11 of the Committee amendments represents a carefully tailored balance of these competing considerations.

Section 11 requires that state certificate-of-need laws cover HMOs no more restrictively than fee-for-service providers. However, contemplating passage of the 1978 Planning Act Amendments' provision to require CON coverage of equipment located in physicians' offices costing more than $150,000, the bill would require states to cover such equipment for both qualified and non-qualified HMOs. States would also be required to cover the inpatient hospital facilities of both qualified and non-qualified HMOs. In order to ensure fair appraisal of HMO certificate-of-need applications, however, the bill sets forth certain limited criteria that must be used in processing qualified HMOs' applications for the purchase of equipment costing more than $150,000 and for new inpatient hospital facilities.

It should be emphasized that these criteria are to be the *sole* criteria utilized in processing such applications. HMO certificate-of-need applications must be judged on the basis of these standards and no other, except to the extent that additional standards conform with the criteria regarding the relationship between HMOs and health a reasonable and cost-effective manner which is consistent with the basic method of operation of the organization and which makes such services available on a long-term basis through physicians and other health professional associated with it.".

PROGRAM ADMINISTRATION

SEC. 12. (a)(1) Section 1306(b)(2) is repealed.

(2) Paragraphs (3), (4), (5), (6), (7), and (8) of section 1306(b) are redesignated as paragraphs (2), (3), (4), (5), (6), and (7), respectively.

(b) Section 1307 is amended by adding the following new subsection at the end thereof:

"(f) The Secretary may make grants to public or non-profit private entities and enter into contracts with private entities for activities to assist in the provision of technical assistance to projects and health maintenance organizations, and in making determinations within the meaning of sections 1308, 1310, and 1312 of the Act.".

(c) Subsection (h) of section 1310 is repealed.

(d) Subsection (c) of section 1312 is repealed.

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HEALTH MAINTENANCE ORGANIZATION AMENDMENTS OF 1978

OCTOBER 13, 1978.—Ordered to be printed

Mr. STAGGERS, from the committee of conference,
submitted the following

CONFERENCE REPORT

[To accompany S. 2534]

The committee of conference on the disagreeing votes of the two Houses on the amendments of the House to the bill (S. 2534) to revise and extend the provisions of title XIII of the Public Health Service Act relating to health maintenance organizations, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the Senate recede from its disagreement to the amendment of the House to the text of the bill and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the House amendment insert the following:

SHORT TITLE, REFERENCE TO ACT

SECTION 1. (a) This Act may be cited as the "Health Maintenance Organization Amendments of 1978".

(b) Whenever in this Act (other than in section 14) an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Public Health Service Act.

EXTENSION OF PROGRAM

SEC. 2. (a) Section 1304(j) is amended (1) by striking out "may be made through September 30, 1978;", and (2) by striking out "1979" and inserting in lieu thereof "1981".

(b) Section 1305(d) is amended by striking out "1980" and inserting in lieu thereof "1981".

would jeopardize the fiscal soundness of the applicant. The additional sentence clarifies that in approving applications for grants, contracts, loans, and loan guarantees under sections 1304 and 1305, the Secretary may not require an applicant to use all available assets for the project if that requirement would jeopardize the fiscal soundness of the applicant (section 12 (b) and (c)).

PROGRAM MANAGEMENT EVALUATION

The Senate bill requires the Comptroller General to evaluate the adequacy and effectiveness of the policies and procedures for the management of the grant and loan programs in Title XIII and the adequacy of the amount of assistance available under Title XIII and to report to the Congress the results of the evaluation not later than May 1, 1979 (section 12).

The House amendment has no similar provision.

The conference substitute conforms to the Senate bill (section 13).

AMENDMENTS TO THE SOCIAL SECURITY ACT

Conflict of interest

The House amendment contains a provision, not included in the Senate bill, which extends the prohibitions of sections 207 and 208 of title 18, United States Code, State or local officers or employees who are responsible for the expenditure of substantial amounts of Medicaid funds, to each individual who formerly was such an officer or employee and to each partner of such an officer or employee (section 13(a)).

The conference substitute conforms to the House amendment (section 14(a)).

Section 1122 review

Section 1122 of the Social Security Act provides for review by State Health Planning Agencies of capital expenditures proposed to be made by health care facilities (such as hospitals and nursing homes) and health maintenance organizations. The coverage of health maintenance organizations includes its establishment and the development of its outpatient facilities and services.

The House amendment contains a provision, not included in the Senate bill, which amends section 1122 to provide that the establishment of an HMO will not be covered and that the development of outpatient facilities and services will be covered only to the extent that a health care facility would be covered for the same activity (section 13(b)).

The conference substitute conforms to the House amendment so that HMO's will be covered equally with other health care facilities (section 14(b)).

Conforming amendments

The House amendment contains a provision, not included in the Senate bill, which makes conforming changes in section 1903(M)(1)(B) of the Social Security Act regarding the administration of the HMO program within HEW (section 13(c)).

The conference substitute conforms to the House amendment (section 14(c)).

FUNDING UNDER OTHER AUTHORITIES FOR THE PROVISION OF HEALTH SERVICES ON A PREPAID BASIS

Section 1313 of the Public Health Service Act limits to title XIII the source of funding for health maintenance organizations and other entities which provide, directly or indirectly, health services to a defined population on a prepaid basis.

The House amendment contains a provision, not included in the Senate bill, which provides that section 1313 does not prohibit the use of funds appropriated under section 319 or 330 of the Public Health Service Act for grants to an entity, other than a health maintenance organization, for the planning and development of health services to be provided on a prepaid basis or for the provision of health services on a prepaid basis (section 8).

The conference substitute conforms to the Senate bill.

HARLEY O. STAGGERS,
PAUL G. ROGERS,
DAVID E. SATTERFIELD,
RICHARDSON PREYER,
JAMES H. SCHEUER,
TIM LEE CARTER,
JAMES T. BROYHILL,
Managers on the Part of the House.
EDWARD KENNEDY,
GAYLORD NELSON,
CLAIBORNE PELL,
WILL D. HATHAWAY,
HARRISON A. WILLIAMS, Jr.,
RICHARD S. SCHWEIKER,
J. JAVITS,
JOHN CHAFEE,
Managers on the Part of the Senate.

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Finder's Aid

P.L. 95-598 (92 Stat. 2549) Approved November 6, 1978
Bankruptcy

Subject	SS Act Section	P.L. Sec.	92 Stat.	H.Rep. 95-595	S.Rep. 95-989	S.Rep. 95-1106
Repealer--Child Support Debt	456(b)	328	2679	285-286 457, 527	75, 79	--

Public Law 95-598
95th Congress

An Act

To establish a uniform Law on the Subject of Bankruptcies.

Nov. 6, 1978
[H.R. 8200]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Title 11, USC.
Bankruptcy.

TITLE I—ENACTMENT OF TITLE 11 OF THE UNITED STATES CODE

SEC. 101. The law relating to bankruptcy is codified and enacted as title 11 of the United States Code, entitled "Bankruptcy", and may be cited as 11 U.S.C. §   , as follows:

11 USC prec. 101 note.

TITLE 11—BANKRUPTCY

CHAPTER Sec.
1. GENERAL PROVISIONS 101
3. CASE ADMINISTRATION 301
5. CREDITORS, THE DEBTOR, AND THE ESTATE 501
7. LIQUIDATION 701
9. ADJUSTMENT OF DEBTS OF A MUNICIPALITY 901
11. REORGANIZATION 1101
13. ADJUSTMENT OF DEBTS OF AN INDIVIDUAL WITH REGULAR INCOME 1301
15. UNITED STATES TRUSTEES 1501

CHAPTER 1—GENERAL PROVISIONS

Sec.
101. Definitions.
102. Rules of construction.
103. Applicability of chapters.
104. Adjustment of dollar amounts.
105. Power of court.
106. Waiver of sovereign immunity.
107. Public access to papers.
108. Extension of time.
109. Who may be a debtor.

§ 101. Definitions

11 USC 101.

In this title—

(1) "accountant" means accountant authorized under applicable law to practice public accounting, and includes professional accounting association, corporation, or partnership, if so authorized;

(2) "affiliate" means—

(A) entity that directly or indirectly owns, controls, or holds with power to vote, 20 percent or more of the outstanding voting securities of the debtor, other than an entity that holds such securities—

(i) in a fiduciary or agency capacity without sole discretionary power to vote such securities; or

(ii) solely to secure a debt, if such entity has not in fact exercised such power to vote;

(B) corporation 20 percent or more of whose outstanding voting securities are directly or indirectly owned, controlled, or held with power to vote, by the debtor, or by an entity

(b) Section 3467 of the Revised Statutes of the United States (31 U.S.C. 192) is amended by striking out "Every" and inserting in lieu thereof the following: "Except with respect to a trustee acting in accordance with the provisions of title 11 of the United States Code every".

Repeal. (c) Section 3469 of the Revised Statutes of the United States (31 U.S.C. 194) is repealed.

Repeal. (d) Section 3473 of the Revised Statutes of the United States (31 U.S.C. 198) is repealed.

Repeal. (e) Section 3474 of the Revised Statutes of the United States (31 U.S.C. 199) is repealed.

(f) The table of sections for title XXXVI of the Revised Statutes of the United States is amended by striking out the items relating to sections 3469, 3473, and 3474.

(g) Section 5256 of the Revised Statutes of the United States (45 U.S.C. 81) is amended by striking out "The laws of the United States providing for proceedings in bankruptcy shall not be held to apply to said corporation.".

SEC. 323. Section 1 of the Act entitled "An Act to provide for the alteration of certain bridges over navigable waters of the United States, for the apportionment of the cost of such alterations between the United States and the owners of such bridges, and for other purposes", approved June 21, 1940 (54 Stat. 497; 33 U.S.C. 511), is amended by striking out "bankruptcy" and inserting "a case under title 11 of the United States Code" in lieu thereof.

Repeal. SEC. 324. Subsection (a) of section 17 of the Act of March 4, 1927 (44 Stat. 1434; 33 U.S.C. 917(a)), is repealed.

SEC. 325. Section 213 of the Transportation Act, 1920 (40 U.S.C. 316), is amended by striking out "bankruptcy" and inserting "case under title 11 of the United States Code" in lieu thereof.

SEC. 326. Section 7 of the Act entitled "An Act to provide conditions for the purchase of supplies and the making of contracts by the United States, and for other purposes", approved June 30, 1936 (49 Stat. 2039; 41 U.S.C. 41), is amended by striking out "bankruptcy" and inserting "cases under title 11 of the United States Code" in lieu thereof.

Repeal. SEC. 327 Subsection (g) of section 733 of the Public Health Service Act (42 U.S.C. 294f) is repealed.

Repeal. SEC. 328. Subsection (b) of section 456 of the Social Security Act (42 U.S.C. 656(b)) is repealed.

SEC. 329. Section 503 (42 U.S.C. 1473) of the Housing Act of 1949 is amended by striking out "This" and inserting "Except as provided in title 11 of the United States Code, this" in lieu thereof.

SEC. 330. Section 701(a) of the Civil Rights Act of 1964 (42 U.S.C. 2000e(a)) is amended by striking out "bankruptcy" and inserting "cases under title 11, United States Code" in lieu thereof.

SEC. 331. Section 802(d) of the Act entitled "An Act to prescribe penalties for certain acts of violence or intimidation, and for other purposes", approved April 11, 1968 (82 Stat. 81; 42 U.S.C. 3602(d)), is amended by striking out "bankruptcy" and inserting "cases under title 11 of the United States Code" in lieu thereof.

SEC. 332. Section 17 of the Boulder Canyon Project Act (43 U.S.C. 617p) is amended by striking out "Claims" and inserting "Except as provided in title 11 of the United States Code, claims" in lieu thereof.

Repeal. 45 USC 662. SEC. 333. Subsection (c) of section 3 of the Emergency Rail Services Act of 1970 (54 U.S.C. 662) is repealed.

SEC. 411. Section 40a of the Bankruptcy Act (11 U.S.C. 68(a)) is amended by striking out "$37,800" and inserting "$50,000" in lieu thereof, and by striking out "$18,900" and inserting "$25,000" in lieu thereof.

Approved November 6, 1978.

LEGISLATIVE HISTORY:

HOUSE REPORT No. 95-595 (Comm. on the Judiciary).
SENATE REPORTS: No. 95-989 accompanying S. 2266 (Comm. on the Judiciary) and No. 95-1106 (Comm. on Finance).
CONGRESSIONAL RECORD:
  Vol. 123 (1977): Oct. 27, 28, considered in House.
  Vol. 124 (1978): Feb. 1, considered and passed House.
    Sept. 7, considered and passed Senate, amended, in lieu of S. 2266.
    Sept. 22, passage vitiated; amendment in the nature of a substitute agreed to by Senate.
    Sept. 28, House concurred in Senate amendment with an amendment.
    Oct. 5, Senate concurred in House amendment with an amendment.
    Oct. 6, House concurred in Senate amendment.

○

95th Congress } HOUSE OF REPRESENTATIVES { Report
1st Session } { No. 95-595

BANKRUPTCY LAW REVISION

REPORT

OF THE

COMMITTEE ON THE JUDICIARY

together with

SEPARATE, SUPPLEMENTAL, AND SEPARATE ADDITIONAL VIEWS

[Including Cost Estimate of the Congressional Budget Office]

[To accompany H.R. 8200]

September 8, 1977.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON : 1977

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95TH CONGRESS } HOUSE OF REPRESENTATIVES { REPORT
1st Session } { No. 95–595

BANKRUPTCY LAW REVISION

SEPTEMBER 8, 1977.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. EDWARDS of California, from the Committee on the Judiciary, submitted the following

REPORT

together with

SEPARATE, SUPPLEMENTAL, AND SEPARATE ADDITIONAL VIEWS

[Including Cost Estimate of the Congressional Budget Office]

[To accompany H.R. 8200]

The Committee on the Judiciary, to whom was referred the bill (H.R. 8200) to establish a uniform law on the subject of Bankruptcies, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass. The committee amendment strikes out all after the enacting clause and inserts a new text, which appears in italic type in the reported bill.

The amendment is an amendment in the nature of a substitute for the bill, incorporating six substantive amendments adopted by the committee, and numerous technical, drafting, and style changes to the bill. A detailed description of the six amendments adopted during committee deliberations is incorporated into the description of the bill contained in this Report, which addresses itself to the amendments in the nature of a substitute. Briefly summarized, they are as follows:

The first amendment provides an alternative to the United States trustee in the appointment of private standing chapter 13 trustees. The amendment permits United States trustees, with the approval of the Attorney General, to employ private standing trustees or public assistant United States trustees to serve in chapter 13 cases.

The second amendment limits the consumer priority in § 507(5) of proposed title 11 to $2,400 per individual.

The third amendment changes section 303(b) of the bill to delete the repealer of section 4(e) of the Perishable Agricultural Commodities Act and replace the repealer with an amendment to section 4(e) of that Act to allow suspension of a license in the event of bankruptcy if the circumstances of the bankruptcy warrant. This changes current

CHAPTER 9. MISCELLANEOUS PROVISIONS

I. Title III—Amendments to Other Laws

Title III of H.R. 8200 contains 36 sections amending other laws of the United States. The general policy followed in title III is to eliminate any special treatment of bankruptcy found in those other laws. Special treatment under current laws takes several forms. First, some laws prescribe preferential treatment of certain claims or creditors in bankruptcy cases, or grant priorities to certain claims or creditors. These special priorities and preferences are inconsistent with bankruptcy policy, which prescribes equality of distribution for all creditors. When an insolvent estate is liquidated and the proceeds distributed under the bankruptcy laws, myriad other laws that reorder the priorities fixed in the bankruptcy code create confusion and unfairness. It is necessary to bring all of the competing claimants into the same form for a determination of the appropriate distribution of limited assets. Equality of distribution is the rule in bankruptcy, and supported by long years of strong bankruptcy policy. The bankruptcy code makes exceptions for certain classes of claims, but these exceptions are based on a weighing of all competing interests in the bankruptcy arena. Other laws that grant priorities do so at the expense of other creditors and to the detriment of the orderly liquidation and distribution of a bankrupt estate. Thus, the bill, in the interest of a coherent bankruptcy policy, eliminates special priorities found in other laws and brings all priorities into the bankruptcy code itself.

The priority most frequently appearing in other laws is a priority for the United States for nontax claims. These claims include contract and tort claims, and loan repayment claims. There have been steady calls for the elimination or reduction of the nontax priority of the United States,[1] especially in bankruptcy cases, where the priority is exercised at the expense of other creditors of the bankrupt. This bill makes the priorities of the United States for nontax claims inapplicable in bankruptcy cases by amendments to the other laws of the United States that grant the priority.

The second category of special treatment of bankruptcy is the exception to discharge. The most notable of these is the exception to discharge for educational loans. This had been discussed in detail elsewhere in this Report.[2] In sum, exceptions to discharge not found in the bankruptcy code are subject to the same criticism that special priorities are: they are not enacted with the balancing of the myriad competing interests in the bankruptcy arena, and frequently are contrary to the two strong bankruptcy policies of a fresh start for the debtor and the equality of treatment of all creditors. The bankruptcy code recognizes certain debts that should be excepted from discharge. Thus, the elimination of miscellaneous exceptions to discharge found in other laws is not an attempt to eliminate exceptions to discharge entirely. Rather, the Committee have considered these other provisions and have attempted to regularize and bring together in one place, the bankruptcy code, the list of debts that are not included in the bankruptcy discharge. In a sense, then, the amendments made by title III to eliminate miscellaneous exceptions to discharge in other laws of the United States are conforming amendments to carry out the discharge policy of proposed title 11.

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[1] Commission of the Bankruptcy Laws of the United States, Report, H.R. Doc. No. 93-137, 93d Cong., 1st Sess., pt. I, at 216-18 (1973) [hereinafter cited as Commission Report]; Plumb, *The Federal Priority in Insolvency: Proposals for Reform*, 70 Mich. L. Rev. 1 (1971).

[2] Chapter 3, *supra*.

Finally, various other laws of the United States provide for certain penalties on the event of bankruptcy. These most often take the form of a denial of a license, grant, or entitlement. The premise of those denials is that bankruptcy itself is sufficiently represensible behavior to warrant the imposition of a sanction against the bankrupt. Such other laws are clearly contrary to the fresh start policy of the bankruptcy laws and do nothing to further regulatory objectives in other laws. They ignore the circumstances surrounding a bankruptcy and operate on the occurrence of the bankruptcy alone. From the study of the causes of bankruptcy,[3] the Committee have become convinced that bankruptcy per se is not something to be punished. Too often, a personal bankruptcy is caused by circumstances beyond the control of the debtor. Excessive emergency medical bills, illness, job layoffs, tort judgments resulting from accidents, and general economic reverses all contribute to individual bankruptcies. These causes are not in themselves adequate grounds on which to deny an individual a license to work after a bankruptcy. To do so would negate the beneficial effects of the protections of the bankruptcy laws, and would prevent rather than facilitate a fresh start. There are, however, circumstances where a bankruptcy has been caused by misdeeds or questionable conduct of the debtor. In those circumstances, of course, the bill permits denial of the license or grant, but only after an appropriate investigation of the circumstances surrounding the bankruptcy.

In addition, in order not to interfere with legitimate regulatory objectives, the bill does not prevent imposition of financial responsibility rules against former debtors under the bankruptcy laws, so long as those rules are not applied discriminatorily, that is, only against former bankrupts. The bankruptcy laws do not forgive compliance with generally applicable financial responsibility rules; neither do they require that former bankrupts comply with extraordinary rules, unless of course, as noted above, the circumstances of the bankruptcy warrant special treatment for the individual involved.

The last group of amendments contained in title III of H.R. 8200 are technical and conforming amendments. They change various cross-references to sections of the Bankruptcy Act found in other laws to the appropriate sections in proposed title 11. They also change style and terminology to conform to the style of proposed title 11, and change references to the Bankruptcy Act itself to references to title 11 of the United States Code.

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[3] *See* COMMISSION REPORT, pt. I, at 33–59; *Hearings on H.R. 31 and H.R. 32 Before the Subcomm. on Civil and Constitutional Rights of the House Comm. on the Judiciary*, 94th Cong., 1st & 2d Sess., ser. 27, pt. 1, at 157–64, 198–202, 300–26.

SECTION 326

This section repeals section 733(g) of the Public Health Service Act, which excepts from discharge for a period of five years certain educational loans. It conforms that Act to the policy expressed in section 523 and 727 of the proposed bankruptcy code and in section 316 of this bill.

SECTION 327

This section amends section 456 of the Social Security Act to repeal subsection (b), which provides an exception to the bankruptcy discharge. This section is to carry out the policy expressed in proposed 11 U.S.C. 523(a).

SECTION 328

This section amends section 503 of the Housing Act of 1949, entitled "Potentially adequate farms," to make a nonassignability provision inapplicable in cases under proposed title 11.

SECTION 329

This section changes a reference in section 701 of the Civil Rights Act of 1964 from trustee in bankruptcy to trustee in a case under title 11 of the United States Code.

SECTION 330

This section changes a reference in section 802 of the Act entitled "An Act to prescribe penalties for certain acts of violence or intimidation, and for other purposes", approved April 11, 1968 (82 Stat. 81; 42 U.S.C. 3602(d)), from trustee in bankruptcy to trustee in a case under title 11 of the United States Code.

SECTION 331

Section 17 of the Boulder Canyon Project Act provides for superpriority for claims of the United States arising out of any contract authorized by that Act. Section 331 of the bill makes the priority inapplicable in cases under title 11 of the United States Code, in conformity with the amendment to section 3466 of the Revised Statutes (section 321(a) of the bill) and the general bankruptcy policy against special priorities for the Government.

SECTION 332

This section repeals that provision of the Emergency Rail Services Act of 1970, which applies only to the seven bankrupt Northeast railroads, that requires the Secretary of the Treasury to demand a superpriority for the Government in connection with loan guarantees under that Act. The repeal will give the Secretary the opportunity to respond to the circumstances of any case that might arise in the future regarding loan guarantees, and does not prohibit or restrict him from demanding as a condition to a guarantee the super-priority that the statute now requires.

[(g) A debt which is a loan insured under the authority of this subpart may be released by a discharge in bankruptcy under title 11 of the United States Code only if such discharge is granted after the expiration of the five-year period beginning on the first date, as specified in section 731(a)(2)(B), when repayment of such loan is required.]

SECTION 456 OF THE SOCIAL SECURITY ACT (42 U.S.C. 656)

PART D—CHILD SUPPORT AND ESTABLISHMENT OF PATERNITY

* * * * * * *

SUPPORT OBLIGATIONS

SEC. 456. (a) The support rights assigned to the State under section 402(a)(26) shall constitute an obligation owed to such State by the individual responsible for providing such support. Such obligation shall be deemed for collection purposes to be collectible under all applicable State and local processes.

(1) The amount of such obligation shall be—

(A) the amount specified in a court order which covers the assigned support rights, or

(B) if there is no court order, an amount determined by the State in accordance with a formula approved by the Secretary, and

(2) Any amounts collected from an absent parent under the plan shall reduce, dollar for dollar, the amount of his obligation under paragraphs (1)(A) and (B).

[(b) A debt which a child support obligation assigned to a State under section 402(a)(26) is not released by a discharge in bankruptcy under the Bankruptcy Act.]

SECTION 503 OF THE HOUSING ACT OF 1949 (42 U.S.C. 1473)

LOANS FOR HOUSING AND BUILDINGS ON POTENTIALLY ADEQUATE FARMS

SEC. 503. If the Secretary determines (a) that, because of the inadequacy of the income of an eligible applicant from the farm to be improved and from other sources, said applicant may not reasonably be expected to make annual repayments of principal and interest in an amount sufficient to repay the loan in full within the period of time prescribed by the Secretary as authorized in this title; (b) that the income of the applicant may be sufficiently increased within a period of not to exceed five years by improvement or enlargement of the farm or an adjustment of the farm practices or methods; and (c) that the applicant has adopted and may reasonably be expected to put into effect a plan of farm improvement, enlargement, or adjusted practices or production which, in the opinion of the Secretary, will increase the applicant's income from said farm within a by Congress in escalating these courts to Article III courts. On the other hand, if I am right that Article III courts are a serious mistake, Article III courts, once built, cannot be easily dismantled, if they can be dismantled at all.

I again express my appreciation for the opportunity to continue an exchange of views upon this extremely important legislation.

United States Trustees

During Floor debate on the bill I propose to offer an amendment which would place the selection of United States Trustees in the Judicial Branch. I shall do this because (1) I feel it is necessary in order to preserve the separation of powers, and (2) to prevent the very probable conflict-of-interest situation which may arise if the Executive Branch, through the Justice Department, is the selector and employer of the United States Trustees.

The amendment which I propose to offer will probably take the form of having the United States Trustees appointed by the Judicial Council following a screening process and recommendation by the Administrative Office of the U.S. Courts. I hope that my colleagues will see fit to join with me on such an amendment.

GEORGE E. DANIELSON.

○

95TH CONGRESS } SENATE { REPORT
2d Session } { No. 95-989

BANKRUPTCY REFORM ACT OF 1978

JULY 14 (legislative day, MAY 17), 1978.—Ordered to be printed

Mr. DECONCINI, from the Committee on the Judiciary, submitted the following

REPORT

[To accompany S. 2266]

The Committee on the Judiciary, to which was referred the bill, S. 2266, to establish a uniform law on the subject of bankruptcies, having considered the same, reports favorably thereon and recommends that the bill in the nature of a substitute do pass. The committee amendment strikes out all after the enacting clause and inserts a new text, which appears in italic type in the reported bill.

PURPOSE OF THE BILL

The purpose of the bill is to modernize the bankruptcy law by codifying a new title 11 that will embody the substantive law of bankruptcy and to make extensive amendments to title 28, Judiciary and Judicial Procedure, that will encompass the structure of the revised bankruptcy courts.

PURPOSE OF THE AMENDMENT

The amendment in the nature of a substitute reflects, testimony received by the committee and the changes that resulted. The purpose of the revised bill remains to modernize the bankruptcy law.

INTRODUCTION

In 1970, Congress created the Commission on the Bankruptcy Laws of the United States to study and recommend changes in bankruptcy laws. The Commission became operational in June 1971, and filed its final report with Congress on July 30, 1973. Its report was in two parts. Part I contained the Commission's findings and recommendations.

Section 521. Debtor's duties

This section lists three duties of the debtor in a bankruptcy case. The Rules of Bankruptcy Procedure will specify the means of carrying out these duties. The first duty is to file with the court a list of creditors and, unless the court orders otherwise, a schedule of assets and liabilities and a statement of his financial affairs. Second, the debtor is required to cooperate with the trustee as necessary to enable the trustee to perform the trustee's duties. Finally, the debtor must surrender to the trustee all property of the estate, and any recorded information, including books, documents, records, and papers, relating to property of the estate. This phrase "recorded information, including books, documents, records, and papers," has been used here and throughout the bill as a more general term, and includes such other forms of recorded information as data in computer storage or in other machine readable forms.

The list in this section is not exhaustive of the debtor's duties. Others are listed elsewhere in proposed title 11, such as in section 343, which requires the debtor to submit to examination, or in the Rules of Bankruptcy Procedure, as continued by § 404(a) of S. 2266, such as the duty to attend any hearing on discharge, Rule 402(2).

Section 522. Exemptions

Subsection (a) of this section defines two terms: "dependent" includes the debtor's spouse, whether or not actually dependent; and "value" means fair market value as of the date of the filing of the petition.

Subsection (b) tracks current law. It permits a debtor the exemptions to which he is entitled under other Federal law and the law of the State of his domicile. Some of the items that may be exempted under Federal laws other than title 11 include:

Foreign Service Retirement and Disability payments, 22 U.S.C. 1104;
Social security payments, 42 U.S.C. 407;
Injury or death compensation payments from war risk hazards, 42 U.S.C. 1717;
Wages of fishermen, seamen, and apprentices, 46 U.S.C. 601;
Civil service retirement benefits, 5 U.S.C. 729, 2265;
Longshoremen's and Harbor Workers' Compensation Act death and disability benefits, 33 U.S.C. 916;
Railroad Retirement Act annuities and pensions, 45 U.S.C. 228 (L);
Veterans benefits, 45 U.S.C. 352(E);
Special pensions paid to winners of the Congressional Medal of Honor, 38 U.S.C. 3101; and
Federal homestead lands on debts contracted before issuance of the patent, 43 U.S.C. 175.

He may also exempt an interest in property in which the debtor had an interest as a tenant by the entirety or joint tenant to the extent that interest would have been exempt from process under applicable nonbankruptcy law.

Under proposed section 541, all property of the debtor becomes property of the estate, but the debtor is permitted to exempt certain time to permit timely action by the creditor to protect his rights, unless the creditor had notice or actual knowledge of the case.

Paragraph (4) excepts debts for fraud incurred by the debtor while acting in a fiduciary capacity or for defalcation, embezzlement, or misappropriation.

Paragraph (5) provides that debts for willful and malicious conversion or injury by the debtor to another entity or the property of another entity are nondischargeable. Under this paragraph "willful" means deliberate or intentional. To the extent that *Tinker* v. *Colwell*, 139 U.S. 473 (1902), held that a less strict standard is intended, and to the extent that other cases have relied on *Tinker* to apply a "reckless disregard" standard, they are overruled.

Paragraph (6) excepts from discharge debts to a spouse, former spouse, or child of the debtor for alimony to, maintenance for, or support of the spouse or child. This language, in combination with the repeal of section 456(b) of the Social Security Act (42 U.S.C. 656(b)) by section 326 of the bill, will apply to make nondischargeable only alimony, maintenance, or support owed directly to a spouse or dependent. What constitutes alimony, maintenance, or support, will be determined under the bankruptcy law, not State law. Thus, cases such as *In re Waller*, 494 F.2d 447 (6th Cir. 1974), are overruled, and the result in cases such as *Fife* v. *Fife*, 1 Utah 2d 281, 265 P.2d 642 (1952) is followed. The proviso, however, makes nondischargeable any debts resulting from an agreement by the debtor to hold the debtor's spouse harmless on joint debts, to the extent that the agreement is in payment of alimony, maintenance, or support of the spouse, as determined under bankruptcy law considerations as to whether a particular agreement to pay money to a spouse is actually alimony or a property settlement.

Paragraph (7) makes nondischargeable certain liabilities for penalties including tax penalties if the underlying tax with respect to which the penalty was imposed is also nondischargeable (sec. 523(a)(7)). These latter liabilities cover those which, but are penal in nature, as distinct from so-called "pecuniary loss" penalties which, in the case of taxes, involve basically the collection of a tax under the label of a "penalty." This provision differs from the bill as introduced, which did not link the nondischarge of a tax penalty with the treatment of the underlying tax. The amended provision reflects the existing position of the Internal Revenue Service as to tax penalties imposed by the Internal Revenue Code (Rev. Rul. 68–574, 1968–2 C.B. 595).

Paragraph (8) follows generally current law and excerpts from discharge student loans until such loans have been due and owing for five years. Such loans include direct student loans as well as insured and guaranteed loans. This provision is intended to be self-executing and the lender or institution is not required to file a complaint to determine the nondischargeability of any student loan.

Paragraph (9) excepts from discharge debts that the debtor owed before a previous bankruptcy case concerning the debtor in which the debtor was denied a discharge other than on the basis of the six-year bar.

Subsection (b) of this section permits discharge in a bankruptcy case of an unscheduled debt from a prior case. This provision is carried over from Bankruptcy Act § 17b. The result dictated by the sub-

Changes In Existing Laws

In the opinion of the Committee on the Judiciary, it is necessary in order to expedite the business of the Senate to dispense with the requirements of subsection 4 of rule XXIX of the Standing Rules of the Senate (relating to the showing of changes in existing laws made by the bill, as reported). The Committee felt this was justified since the Committee on Finance has a 30-day sequential referral following the date the bill is reported from the Judiciary Committee and further changes could be expected from the Committee on Finance. It is anticipated that completed changes in the existing law section will be available following termination of the referral to the Committee on Finance.

○

Calendar No. 1026

95TH CONGRESS } SENATE { REPORT
2d Session } { No. 95-1106

BANKRUPTCY REFORM ACT OF 1978

AUGUST 10 (legislative day, MAY 17), 1978.—Ordered to be printed

Mr. LONG, from the Committee on Finance,
submitted the following

REPORT

[To accompany S. 2266]

The Committee on Finance, to which was referred the bill (S. 2266) to establish a uniform law on the subject of bankruptcy, having considered the same, reports favorably thereon with amendments and recommends that the bill as amended do pass.

I. SUMMARY

S. 2266, the Bankruptcy Reform Act of 1978, was reported by the Committee on the Judiciary on July 14, 1978 (S. Rept. 95-989), and, by prior agreement, was referred to the Committee on Finance for a period not to exceed 30 days for consideration and recommendations concerning tax-related provisions of the bill. The referral specifically covers sections 346, 505, 507, 523, 728, 1146 and 1331 of the proposed new title 11 of the United States Code (contained in sec. 101 of the bill). These provisions deal with determining tax liabilities in bankruptcy, clarifying the jurisdiction of different courts to rule on these issues, and defining the priority and dischargeability of tax claims against the debtor's estate.

S. 2266 and H.R. 8200, the House-passed bill on the same subject, would modernize bankruptcy law for the first time in 40 years, in light of major changes in debtor-creditor relations during this period. The current bankruptcy system originated in 1898, and the last major revision of the Bankruptcy Act occurred in 1938.

The overall objectives of S. 2266 and H.R. 8200 are to make bankruptcy procedures more efficient, to balance more equitably the interests of different creditors, to give greater recognition to the interests of general unsecured creditors who enjoy no priority in the distribution of the assets of the debtor's estate, and to give the debtor a less encumbered "fresh start" after bankruptcy.

No material re social security in this report.

VII. CHANGES IN EXISTING LAW

In the opinion of the Committee on Finance, in order to expedite the business of the Senate, it is necessary to dispense with the requirements of subsection 4 of Rule XXIX of the Standing Rules of the Senate (relating to the showing of changes in existing law made by the bill, as reported).

○

Finder's Aid

P.L. 95-600 (92 Stat. 2763) Approved November 6, 1978
Revenue Act of 1978

Subject	SS Act Section	P.L. Section	92 Stat.	H.Rep. 95-1445	S.Rep. 95-1263	H.C.Rep. 95-1800
Waiver of Benefits (Technical Amendment)	202(v)	703(j)(14)(A)	2942	--	--	--
Change Jurisdiction From Treasury to Transportation (Technical Amendment)	205(p)(3)	703(j)(14)(B)	2942	--	--	--
Exclusion of Employer Educational Assistance Benefits	209(q)	164(b)(4)	2814	--	98-103	--
Technical Amendment	210(a)(6)(B)	703(j)(14)(C)	2942	--	--	--
Technical Amendment	211(a)(2)	703(j)(14)(D)	2942	--	--	--
Technical Amendment	211(c)(6)	703(j)(14)(E)	2942	--	--	--
Limits on Pay to Puerto Rico, etc. Fiscal Provision	1108(a)(1)(E)	802(b)(1)	2945	--	222-230	298
Limits on Pay to Puerto Rico, etc. Fiscal Provision	1108(a)(1)(F)	802(b)(1)(C)	2945	--	--	--
Limits on Pay to Puerto Rico, etc. Fiscal Provision	1108(a)(2)(E)	802(b)(2)(B)	2945	--	--	--
Limits on Pay to Puerto Rico, etc. Fiscal Provision	1108(a)(2)(F)	802(b)(2)(C)	2945	--	--	--
Limits on Pay to Puerto Rico, etc. Fiscal Provision	1108(a)(3)(E)	802(b)(3)(B)	2946	--	--	--
Limits on Pay to Puerto Rico, etc. Fiscal Provision	1108(a)(3)(F)	802(b)(3)(C)	2946	--	--	--
Alternate Federal Pay for Medicaid (Fiscal Limit)	1118	802(a)	2945	--	222-230	--
Increased Grant to States for Social Services	2002(a)(2)(A)	801(a)	2944	--	231-235	295

Public Law 95-600
95th Congress

An Act

To amend the Internal Revenue Code of 1954 to reduce income taxes, and for other purposes.

Nov. 6, 1978
[H.R. 13511]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Revenue Act of 1978.

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Revenue Act of 1978".

(b) TABLE OF CONTENTS.—

Sec. 1. Short title; table of contents.
Sec. 2. Amendment of 1954 Code.
Sec. 3. Policy with respect to additional tax reductions.

TITLE I—PROVISIONS PRIMARILY AFFECTING INDIVIDUAL INCOME TAX

Subtitle A—Tax Reductions and Extensions

Sec. 101. Widening of brackets; rate cuts in certain brackets; increase in zero bracket amounts.
Sec. 102. Personal exemptions increased to $1,000.
Sec. 103. Earned income credit made permanent.
Sec. 104. Increase in and simplification of the earned income tax credit.
Sec. 105. Advance payment of earned income credit.
Sec. 106. Application of certain changes in the case of fiscal year taxpayers.

Subtitle B—Itemized Deductions

Sec. 111. Repeal of nonbusiness deduction for State and local taxes on gasoline and other motor fuels.
Sec. 112. Unemployment compensation.

Subtitle C—Credits

Sec. 121. Payments to related individuals under child care credit.

Subtitle D—Deferred Compensation

PART I—DEFERRED COMPENSATION PROVISIONS

Sec. 131. Deferred compensation plans with respect to service for State and local governments.
Sec. 132. Certain private deferred compensation plans.
Sec. 133. Clarification of deductibility of payments of deferred compensation, etc., to independent contractors.
Sec. 134. Tax treatment of cafeteria plans.
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PART II—EMPLOYEE STOCK OWNERSHIP PLANS

Sec. 141. ESOPS.
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Sec. 143. Qualified plans required to pass through voting rights on employer securities.

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Sec. 152. Simplified employee pensions.
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Sec. 156. Rollover of section 403(b) annuities permitted.
Sec. 157 Individual retirement account technical changes.

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Sec. 161. Certain Government scholarship and award programs.
Sec. 162. Cancellation of student loans.
Sec. 163. Tax counseling for the elderly.
Sec. 164. Exclusion of value of certain educational assistance programs.

TITLE II—TAX SHELTER PROVISIONS

Subtitle A—Provisions Related to At Risk Rules

Sec. 201. Extension of section 465 at risk rules to all activities other than real estate.
Sec. 202. Extension of at risk provisions to closely held corporations.
Sec. 203. Recapture of losses where amount at risk is less than zero.
Sec. 204. Effective dates.

Subtitle B—Partnership Provisions

Sec. 211. Penalty for failure to file partnership return.
Sec. 212. Extension of statute of limitations in the case of partnership items.

TITLE III—PROVISIONS PRIMARILY AFFECTING BUSINESS INCOME TAX

Subtitle A—Corporate Rate Reductions

Sec. 301. Corporate rate reductions.

Subtitle B—Credits

Sec. 311. 10-percent investment tax credit and $100,000 limitation on used property made permanent.
Sec. 312. Increase in limitation on investment credit to 90 percent of tax liability.
Sec. 313. Investment credit for pollution control facilities.
Sec. 314. Investment credit for certain single purpose agricultural or horticultural structures.
Sec. 315. Investment credit allowed for certain rehabilitated buildings.
Sec. 316. Tax treatment of the investment credit in the case of cooperative organizations.
Sec. 317. Transfers to ConRail not treated as dispositions for purposes of the investment credit.

Subtitle C—Targeted Jobs Credit; WIN Credit

Sec. 321. Targeted jobs credit.
Sec. 322. Work incentive program credit changes.

Subtitle D—Tax Exempt Bonds

Part I—Industrial Development Bonds

Sec. 331. Increase in limit on small issues of industrial development bonds.
Sec. 332. Local furnishing of electric energy.
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Part II—Other Tax-Exempt Bond Provisions

Sec. 336. Declaratory judgment procedure for judicial review of determinations relating to governmental obligations.
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Subtitle E—Small Business Provisions

PART I—PROVISIONS RELATING TO SUBCHAPTER S

Sec. 341. Subchapter S corporations allowed 15 shareholders.
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Sec. 343. Extension of period for making subchapter S elections.
Sec. 344. Effective date.

PART II—OTHER PROVISIONS

Sec. 345. Small business corporation stock.

Subtitle F—Accounting Provisions

Sec. 351. Treatment of certain closely held farm corporations for purposes of rule requiring accrual accounting.
Sec. 352. Accounting for growing crops.
Sec. 353. Treatment of certain farms for purposes of rule requiring accrual accounting.

Subtitle G—Other Business Provisions

Sec. 361. Disallowance of certain deductions for yachts, hunting lodges, etc.
Sec. 362. Deficiency dividend procedure for regulated investment companies.
Sec. 363. Real estate investment trust provisions.
Sec. 364. Contributions in aid of construction.
Sec. 365. Liabilities of controlled corporations.
Sec. 366. Medical expense reimbursement plans.
Sec. 367. Three-year extension of provision for 60-month depreciation of expenditures to rehabilitate low-income rental housing.
Sec. 368. Delay in application of new net operating loss rules.
Sec. 369. Use of certain expired net operating loss carryovers.
Sec. 370. Income from certain railroad rolling stock treated as income from sources within the United States.
Sec. 371. Net operating losses attributable to product liability losses.
Sec. 372. Exclusion from gross income with respect to magazines, paperbacks, and records returned after the close of the taxable year.
Sec. 373. Qualified discount coupons redeemed after close of taxable year.

TITLE IV—CAPITAL GAINS; MINIMUM TAX; MAXIMUM TAX

Subtitle A—Capital Gains

Sec. 401. Repeal of alternative tax on capital gains of individuals.
Sec. 402. Increased capital gains deductions for individuals.
Sec. 403. Reduction of alternative capital gains tax for corporations.
Sec. 404. One-time exclusion of gain from sale of principal residence by individual who has attained age 55.
Sec. 405. Waiver of certain 18-month rules of section 1034 when sale of residence is connected with commencing work at new place.

Subtitle B—Minimum Tax Provisions

Sec. 421. Alternative minimum tax for taxpayers other than corporations.
Sec. 422. Treatment of intangible drilling cost for purposes of the minimum tax.

Subtitle C—Maximum Tax Provisions

Sec. 441. Treatment of capital gains for purposes of the maximum tax.
Sec. 442. Determination of personal service income from nonsalaried trade or business activities.

TITLE V—OTHER TAX PROVISIONS

Subtitle A—Administrative Provisions

Sec. 501. Reporting requirements with respect to charged tips.
Sec. 502. Extension of optional small tax case procedures and expansion authority of commissioners of Tax Court.
Sec. 503. Disclosure of return information to certain Federal officers and employ for purposes of tax administration, etc.
Sec. 504. Refund adjustments for amounts held under claim of right.

Subtitle B—Estate and Gift Tax Provisions

Sec. 511. Reduction of value taken into account for estate tax purposes wh spouse of decedent materially participated in farm or other business.
Sec. 512. Treatment of certain interests held by decedent's family for purposes the extension of time for payment of estate tax provided by section 616
Sec. 513. Subordination of special liens for additional estate tax attributable farm, etc., valuation.
Sec. 514. Amendment of governing instruments to meet requirements for gifts split interest to charity.
Sec. 515. Deferral of carryover basis rules.

Subtitle C—Other Excise Tax Provisions

Sec. 520. Reduction of administration tax on private foundations.
Sec. 521. Excise tax on certain gaming devices.
Sec. 522. Treatment of certain private foundations for purposes of section 4942.

Subtitle D—Income Tax Provisions

Sec. 530. Controversies involving whether individuals are employees for purposes the employment taxes.
Sec. 531. Certain original stockholders of cooperative housing corporations.

Subtitle E—Other Income Tax Provisions

Sec. 540. Deposits in certain branches of Puerto Rican savings and loan associ tions.
Sec. 541. Taxation of Alaska Native Claims Settlement Act corporations.
Sec. 542. Replacement of livestock with other farm property where there has be environmental contamination.
Sec. 543. Certain payments not included in gross income.

Subtitle F—Studies

Sec. 551. Study of simplification of tax returns.
Sec. 552. Study of tax incentives for expenditures required by Occupational Safety and Health Administration and Mining Health and Safety Admini tration.
Sec. 553. Study of taxation of nonresident alien real estate transactions in the United States.
Sec. 554. Report on effectiveness of jobs credit.
Sec. 555. Study of effects of changes in the tax treatment of capital gains on stim lating investment and economic growth.

TITLE VI—GENERAL STOCK OWNERSHIP CORPORATIONS

Sec. 601. Establishment and taxation of general stock ownership corporations and their shareholders.

TITLE VII—TECHNICAL CORRECTIONS OF THE TAX REFORM ACT OF 1976

Sec. 701. Technical amendments to income tax provisions and administrative provisions.
Sec. 702. Technical, clerical, and conforming amendment to estate and gift tax provisions.
Sec. 703. Corrections of punctuation, spelling, incorrect cross references, etc.

TITLE VIII—AMENDMENTS RELATING TO SOCIAL SECURITY ACT

Sec. 801. Grants to States for social services.
Sec. 802. Change in public assistance matching formula, and increase in amount of public assistance dollar limitations, for Puerto Rico, the Virgin Islands, and Guam in fiscal year 1979.

SEC. 2. AMENDMENT OF 1954 CODE.

Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1954. 26 USC 1 *et seq.*

SEC. 3. POLICY WITH RESPECT TO ADDITIONAL TAX REDUCTIONS.

As a matter of national policy the rate of growth in Federal outlays, adjusted for inflation, should not exceed 1 percent per year between fiscal year 1979 and fiscal year 1983; Federal outlays as a percentage of gross national product should decline to below 21 percent in fiscal year 1980, 20.5 percent in fiscal year 1981, 20 percent in fiscal year 1982 and 19.5 percent in fiscal year 1983; and the Federal budget should be balanced in fiscal years 1982 and 1983. If these conditions are met, it is the intention that the tax-writing committees of Congress will report legislation providing significant tax reductions for individuals to the extent that these tax reductions are justified in the light of prevailing and expected economic conditions.

TITLE I—PROVISIONS PRIMARILY AFFECTING INDIVIDUAL INCOME TAX

Subtitle A—Tax Reductions and Extensions

SEC. 101. WIDENING OF BRACKETS; RATE CUTS IN CERTAIN BRACKETS; INCREASE IN ZERO BRACKET AMOUNTS.

(a) RATE REDUCTION.—Section 1 (relating to tax imposed) is amended to read as follows:

"SECTION 1. TAX IMPOSED. 26 USC 1.

"(a) MARRIED INDIVIDUALS FILING JOINT RETURNS AND SURVIVING SPOUSES.—There is hereby imposed on the taxable income of—

"(1) every married individual (as defined in section 143) who makes a single return jointly with his spouse under section 6013, and

"(2) every surviving spouse (as defined in section 2(a)),

a tax determined in accordance with the following table:

"If taxable income is:	The tax is:
Not over $3,400	No Tax.
Over $3,400 but not over $5,500	14% of excess over $3,400.
Over $5,500 but not over $7,600	$294, plus 16% of excess over $5,500.
Over $7,600 but not over $11,900	$630, plus 18% of excess over $7,600.
Over $11,900 but not over $16,000	$1,404, plus 21% of excess over $11,900.
Over $16,000 but not over $20,200	$2,265, plus 24% of excess over $16,000.
Over $20,200 but not over $24,600	$3,273, plus 28% of excess over $20,200.
Over $24,600 but not over $29,900	$4,505, plus 32% of excess over $24,600.
Over $29,900 but not over $35,200	$6,201, plus 37% of excess over $29,900.
Over $35,200 but not over $45,800	$8,162, plus 43% of excess over $35,200.
Over $45,800 but not over $60,000	$12,720, plus 49% of excess over $45,800.

employer. A partnership shall be treated as the employer of each partner who is an employee within the meaning of paragraph (2).

"(4) ATTRIBUTION RULES.—

"(A) OWNERSHIP OF STOCK.—Ownership of stock in a corporation shall be determined in accordance with the rules provided under subsections (d) and (e) of section 1563 (without regard to section 1563(e)(3)(C)).

"(B) INTEREST IN UNINCORPORATED TRADE OR BUSINESS.—The interest of an employee in a trade or business which is not incorporated shall be determined in accordance with regulations prescribed by the Secretary, which shall be based on principles similar to the principles which apply in the case of subparagraph (A).

"(5) CERTAIN TESTS NOT APPLICABLE.—An educational assistance program shall not be held or considered to fail to meet any requirements of subsection (b) merely because—

"(A) of utilization rates for the different types of educational assistance made available under the program; or

"(B) successful completion, or attaining a particular course grade, is required for or considered in determining reimbursement under the program.

"(6) RELATIONSHIP TO CURRENT LAW.—This section shall not be construed to affect the deduction or inclusion in income of amounts (not within the exclusion under this section) which are paid or incurred, or received as reimbursement, for educational expenses under section 117, 162 or 212.

"(7) DISALLOWANCE OF EXCLUDED AMOUNTS AS CREDIT OR DEDUCTION.—No deduction or credit shall be allowed under any other section of this chapter for any amount excluded from income by reason of this section.

"(d) TERMINATION.—This section shall not apply to taxable years beginning after December 31, 1983."

(b) TREATMENT OF EMPLOYER EDUCATIONAL ASSISTANCE BENEFITS FOR PURPOSES OF WITHHOLDING, UNEMPLOYMENT TAXES, AND SOCIAL SECURITY TAXES.—

(1) Section 3401(a) (relating to the definition of wages for purposes of collection of income tax at the source) is amended—

(A) by striking out "or" at the end of paragraph (16);

(B) by striking out the period at the end of paragraph (17); and

(C) by adding at the end thereof the following new paragraph:

"(18) for any payment made~~, or~~ benefit furnished, to or for the benefit of an employee if at the time of such payment or such furnishing it is reasonable to believe that the employee will be able to exclude such payment or benefit from income under section 124.".

(2) Section 3306(b) (relating to the definition of wages for purposes of the Federal Unemployment Tax Act) is amended—

(A) by striking out "or" at the end of paragraph (11);

(B) by striking out the period at the end of paragraph (12) and inserting in lieu thereof "; or"; and

(C) by adding at the end thereof the following new paragraph:

"(13) any payment made, or benefit furnished, to or for the benefit of an employee if at the time of such payment or such furnishing it is reasonable to believe that the employee will be able to exclude such payment or benefit from income under section 127.".

(3) Section 3121(a) (relating to the definition of wages for purposes of the Federal Insurance Contributions Act) is amended—

(A) by striking out "or" at the end of paragraph (16);

(B) by striking out the period at the end of subparagraph (17) and inserting in lieu thereof "; or"; and

(C) by adding at the end thereof the following new paragraph:

"(18) any payment made, or benefit furnished, to or for the benefit of an employee if at the time of such payment or such furnishing it is reasonable to believe that the employee will be able to exclude such payment or benefit from income under section 127.".

(4) Section 209 of the Social Security Act is amended—

(A) by striking out "or" at the end of subsection (o);

(B) by striking out the period at the end of subsection (p) and inserting in lieu thereof "; or"; and

(C) by inserting after subsection (p) and before the sentence beginning with "For purposes of this title, in the case of domestic service" the following new subsection:

"(q) Any payment made, or benefit furnished, to or for the benefit of an employee if at the time of such payment or such furnishing it is reasonable to believe that the employee will be able to exclude such payment or benefit from income under section 127 of the Internal Revenue Code of 1954."

(c) CLERICAL AMENDMENT.—The table of sections for such part is amended by striking out the item relating to section 124 and inserting in lieu thereof the following:

"Sec. 124. Educational assistance programs.
"Sec. 125. Cross references to other Acts.".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to taxable years beginning after December 31, 1978.

TITLE II—TAX SHELTER PROVISIONS

Subtitle A—Provisions Related To At Risk Rules

SEC. 201. EXTENSION OF SECTION 465 AT RISK RULES TO ALL ACTIVITIES OTHER THAN REAL ESTATE.

(a) EXTENSION.—Subsection (c) of section 465 (relating to activities to which section applies) is amended by adding at the end thereof the following new paragraph:

"(3) EXTENSION TO OTHER ACTIVITIES.—

"(A) IN GENERAL.—In the case of taxable years beginning after December 31, 1978, this section also applies to each activity—

"(i) engaged in by the taxpayer in carrying on a trade or business or for the production of income, and

"(ii) which is not described in paragraph (1).

"(B) AGGREGATION OF ACTIVITIES WHERE TAXPAYER ACTIVELY PARTICIPATES IN MANAGEMENT OF TRADE OR BUSI-

(j) AMENDMENTS RELATING TO DEADWOOD PROVISIONS.—

(1) TAX EXEMPT GOVERNMENTAL OBLIGATIONS.—

(A) The heading of paragraph (1) of section 103(b) is amended to read as follows:

"(1) SUBSECTION (a) (1) OR (2) NOT TO APPLY.—".

(B) Paragraph (1) of section 103(c) is amended by striking out "(a) (1) or (4)" each place it appears (including in the paragraph heading) and inserting in lieu thereof "(a) (1) or (2)".

(C) Subparagraph (A) of section 103(c)(2) is amended by striking out "subsection (a) (1) or (2) or (4)" and inserting in lieu thereof "subsection (a) (1) or (2)".

(D) Paragraph (5) of section 103(c) is amended by striking out "subsection (d)(2)(A)" and inserting in lieu thereof "paragraph (2)(A)".

(E) Subsection (d) of section 103 is amended by striking out "subsection (c)(4)(G)" and inserting in lieu thereof "subsection (b)(4)(G)".

(2) AMENDMENTS RELATING TO SECTION 311(d)(2).—

(A) Subsection (b) of section 2 of the Bank Holding Company Tax Act of 1976 is amended—

(i) by striking out "subparagraph (F)" and inserting in lieu thereof "subparagraph (E)", and

(ii) by striking out "subparagraph (G)" and inserting in lieu thereof "subparagraph (F)".

(B) Subparagraph (H) of section 311(d)(2) is redesignated as subparagraph (G).

(C) The amendments made by this paragraph shall take effect as if included in section 2(b) of the Bank Holding Company Tax Act of 1976.

(3) AMENDMENT TO SECTION 453(c).—Paragraph (3) of section 453(c) is amended—

(A) by striking out "(or by the corresponding provisions of prior revenue laws)" in the first sentence, and

(B) by striking out the last sentence.

(4) AMENDMENT OF SECTION 801(g).—Paragraphs (1)(B)(ii) and (7) of section 801(g) are each amended by striking out "subparagraph (A), (B), (C), (D), or (E) of section 805(d)(1)" and inserting in lieu thereof "any paragraph of section 805(d)".

(5) AMENDMENT OF SECTION 1033(a)(2).—Clause (ii) of section 103(a)(2)(A) is amended by striking out "subsection (c)" and inserting in lieu thereof "subsection (b)".

(6) AMENDMENT OF SECTION 1375(a).—Paragraph (2) of section 1375(a) is amended by striking out "such excess" each place it appears and inserting in lieu thereof "such gain".

(7) AMENDMENT OF SECTION 1561(b)(3).—Paragraph (3) of section 1561(b) is amended by striking out "804(a)(4)" and inserting in lieu thereof "804(a)(3)".

(8) AMENDMENTS OF SECTION 1402.—

(A) The last paragraph of section 1402(a) of the Internal Revenue Code of 1954 (definition of net earnings from self-employment) is amended by striking out "subsection (i)" each place it appears and inserting in lieu thereof "subsection (h)".

(B) Section 1402(c)(6) of such Code (definition of trade or business) is amended by striking out "subsection (h)" and inserting in lieu thereof "subsection (g)".

(9) AMENDMENT TO SECTION 46(a).—Subparagraph (C) of section 1901(b)(1) of the Tax Reform Act of 1976 is amended by striking

out “Section 46(a)(3)” and inserting in lieu thereof “Section 46(a)(4)”.

(10) Amendment relating to section 6504.—Subparagraph (2) of section 1901(b)(37) of the Tax Reform Act of 1976 is amended by striking out “6515” and inserting in lieu thereof “6504”.

(11) Territories.—Subsection (c) of section 1901 of the Tax Reform Act of 1976 (relating to Territories) is amended by striking out paragraph (1) thereof.

(12) Estate and gift taxes effective date.—Subsection (c) of section 1902 of the Tax Reform Act of 1976 is amended to read as follows:

“(c) Effective Dates.—

“(1) Estate tax amendments.—The amendments made by paragraphs (1) through (8), and paragraphs (12) (A), (B), and (C), of subsection (a) and by subsection (b) shall apply in the case of estates of decedents dying after the date of the enactment of this Act, and the amendment made by paragraph (9) of subsection (a) shall apply in the case of estates of decedents dying after December 31, 1970.

“(2) Gift tax amendments.—The amendments made by paragraphs (10), (11), and (12) (D) and (E) of subsection (a) shall apply with respect to gifts made after December 31, 1976.”

(13) Effective date for amendment made by section 1904(a)(22)(A).—Notwithstanding section 1904(d) of the Tax Reform Act of 1976, the amendment made by section 1904(a)(22)(A) of such Act shall take effect on the date of the enactment of such Act.

(14) Amendments to social security act.—

(A) Section 202(v) of the Social Security Act is amended by striking out “section 1402(h)” each place it appears and inserting in lieu thereof “section 1402(g)”.

(B) Section 205(p)(3) of such Act is amended by striking out “Secretary of the Treasury” and inserting in lieu thereof “Secretary of Transportation”.

(C) Section 210(a)(6)(B)(v) of such Act is amended by striking out “Secretary of the Treasury” and inserting in lieu thereof “Secretary of Transportation”.

(D) Section 211(a)(2) of such Act is amended by striking out “(other than interest described in section 35 of the Internal Revenue Code of 1954)”.

(E) Section 211(c)(6) of such Act is amended by striking out “section 1402(h)” and inserting in lieu thereof “section 1402(g)”.

(k) Capital Loss Carryovers.—Clause (ii) of section 1212(a)(1)(C) lating to capital loss carryovers for foreign expropriation losses) is ended by striking out “exceeding the loss year” and inserting in u thereof “succeeding the loss year”.

(l) Amendments Relating to Certain Aircraft Museums.—

(1) Paragraph (2) of section 4041(h) (defining aircraft museum) is amended by striking out “term ‘aircraft’ means” and inserting in lieu thereof “term ‘aircraft museum’ means”.

(2) Subsection (i) of section 4041 (as added by section 1904(a)(1)(C) of the Tax Reform Act of 1976) is redesignated as subsection (j).

(3) Subsection (d) of section 6427 (relating to repayment of tax on fuels used by certain aircraft museums) is amended by

striking out "Secretary or his delegate" and inserting in l thereof "Secretary".

(4) Paragraph (1) of section 7609(c) (defining summons to whi section applies) is amended by striking out "6427(e)(2)" a inserting in lieu thereof "6427(f)(2)".

(m) INSPECTION BY COMMITTEE OF CONGRESS.—Paragraph (2) section 6104(a) (relating to inspection by committee of Congress) amended by striking out "Section 6103(d)" and inserting in li thereof "Section 6103(f)".

(n) AMENDMENT OF SECTION 6501.—Subsections (h), (j), and (o) section 6501 are each amended by striking out "section 6213(b)(2 and inserting in lieu thereof "section 6213(b)(3)".

(o) CONFORMING AMENDMENTS TO NEW DEFINITION OF TAXA INCOME.—

(1) Subparagraph (A) of section 443(b)(2) (relating to computa tion based on 12-month period) is amended—

(A) by striking out "taxable income" the second and thi places it appears in clause (i) and inserting in lieu thereof "modified taxable income", and

(B) by amending clause (ii) to read as follows:

"(ii) the tax computed on the sum of the modifie taxable income for the short period plus the zero bracke amount."

(2) Paragraph (1) of section 443(b) is amended by striking out "gross income for such short period (minus the deductions allowed by this chapter for the short period, but only the adjusted amount of the deductions for personal exemptions)" and insert ing in lieu thereof "modified taxable income for such shor period".

(3) Subsection (b) of section 443 is amended by adding at the end thereof the following new paragraph:

"(3) MODIFIED TAXABLE INCOME DEFINED.—For purposes of this subsection the term 'modified taxable income' means, with respect to any period, the gross income for such period minus the deductions allowed by this chapter for such period (but, in the case of a short period, only the adjusted amount of the deductions for personal exemptions)."

(4) The amendments made by this subsection shall apply to taxable years beginning after December 31, 1976.

(p) CONFORMING AMENDMENTS TO REPEAL OF SECTION 317 OF TRAD EXPANSION ACT OF 1962.—

(1) AMENDMENTS OF SECTION 172.—

(A) Subparagraph (A) of section 172(b)(1) (relating to years to which loss may be carried) is amended to read as follows

"(A) Except as provided in subparagraphs (D), (E), (F), and (G), a net operating loss for any taxable year shall be a net operating loss carryback to each of the 3 taxable years preceding the taxable year of such loss."

(B) Paragraph (3) of section 172(b) (relating to special rules) is amended by striking out subparagraphs (A) and (B) and by redesignating subparagraphs (C), (D), and (E) as subparagraphs (A), (B), and (C), respectively.

(C) Subparagraph (B) of section 172(b)(3) (as redesignated by subparagraph (B)) is amended by striking out "subparagraph (C)(iii)" each place it appears and inserting in lie thereof "subparagraph (A)(iii)".

(2) Amendment of section 6501(h).—Subsection (h) of section 6501 (relating to net operating loss or capital loss carryback) is amended by striking out the last sentence.

(3) Amendment of section 6511(d)(2).—The first sentence of section 6511(d)(2)(A) (relating to special period of limitation for net operating loss or capital loss carrybacks) is amended by striking out "except that—" and all that follows down through the period at the end of such sentence and inserting in lieu thereof the following: "except that with respect to an overpayment attributable to the creation of, or an increase in a net operating loss carryback as a result of the elimination of excessive profits by a renegotiation (as defined in section 1481(a)(1)(A)), the period shall not expire before the expiration of the 12th month following the month in which the agreement or order for the elimination of such excessive profits becomes final."

(4) Effective date.—The amendments made by this subsection shall apply with respect to losses sustained in taxable years ending after the date of the enactment of this Act.

(q) Conforming Amendment To Repeal of Section 2 of the Emergency Insured Student Loan Act of 1969.—

(1) In general.—Paragraph (5) of section 103(d) (relating to arbitrage bonds) is amended by striking out "section 2 of the Emergency Insured Student Loan Act of 1969" and inserting in lieu thereof "section 438 of the Higher Education Act of 1965".

(2) Effective date.—The amendment made by paragraph (1) shall apply with respect to payments made by the Commissioner of Education after December 31, 1976.

(r) Effective Date.—Except as otherwise provided, the amendments made by this section shall take effect on October 4, 1976.

TITLE VIII—AMENDMENTS RELATING TO SOCIAL SECURITY ACT

SEC. 801. GRANTS TO STATES FOR SOCIAL SERVICES.

(a) Amount To Be Allocated to States.—Section 2002(a)(2)(A) of the Social Security Act is amended—

(1) by striking out "$2,500,000,000" and inserting in lieu thereof "the amount specified in clause (ii)";

(2) by inserting "(i)" after "(2)(A)"; and

(3) by adding the following clause at the end thereof:

"(ii) The amount specified for purposes of clause (i) is $2,500,000,000 for fiscal years prior to fiscal year 1979, $2,700,000,000 for fiscal year 1979, and $2,500,000,000 for fiscal years after fiscal year 1979.".

(b) Additional Amount for Child Day Care Services in Fiscal Year 1979.—Section 3 of Public Law 94-401 is amended—

(1) in the matter preceding paragraph (1) of subsection (a)—

(A) by striking out the word "and" which appears after "1977,", and

(B) by inserting after "1978," the following: "and the fiscal year ending September 30, 1979,",

(2) in subsection (a)(1), by adding after and below subparagraph (B) the following new subparagraph:

"(C) 107.407 per centum of the amount of the limitation so imposed (as determined without regard to this section) in the case of such fiscal year ending September 30, 1979, or",

(3) in subsection (a)(2), by striking out "or either such fiscal year" and inserting in lieu thereof "or any such fiscal year",

(4) in subsection (b), by striking out "or either fiscal year" and inserting in lieu thereof "or any fiscal year",

(5) in subsections (c)(1) and (c)(2)(A), by striking out "or either fiscal year" and inserting in lieu thereof "or any fiscal year (other than the fiscal year ending September 30, 1979)",

(6) in subsection (d)(1)—

(A) by striking out the word "or" which appears after "1977,", and

(B) by inserting after "1978" the following: ", or the fiscal year ending September 30, 1979", and

(7) in subsection (d)(2), by striking out "for either such fiscal year" and inserting in lieu thereof "for any such fiscal year".

SEC. 902. CHANGE IN PUBLIC ASSISTANCE MATCHING FORMULA, AND INCREASE IN AMOUNT OF PUBLIC ASSISTANCE DOLLAR LIMITATIONS, FOR PUERTO RICO, THE VIRGIN ISLANDS, AND GUAM IN FISCAL YEAR 1979.

(a) **Public Assistance Matching Formula.**—Section 1118 of the Social Security Act is amended by adding at the end thereof the following new sentence: "For purposes of the preceding sentence, the term 'Federal medical assistance percentage' shall, in the case of Puerto Rico, the Virgin Islands, and Guam, mean 75 per centum when applied to quarters in the fiscal year ending September 30, 1979.".

(b) **Dollar Limitations.**—Subsection (a) of section 1108 of such Act is amended—

(1) in paragraph (1)—

(A) by striking out "or" at the end of clause (D),

(B) by striking out the semicolon at the end of clause (E) and inserting in lieu thereof "other than the fiscal year 1979, or"; and

(C) by adding at the end thereof the following new subparagraph:

"(F) $72,000,000 with respect to the fiscal year 1979;",

(2) in paragraph (2)—

(A) by striking out "or" at the end of clause (D),

(B) by striking out "; and" at the end of clause (E) and inserting in lieu thereof "other than the fiscal year 1979, or", and

(C) by adding at the end thereof the following new subparagraph:

"(F) $2,400,000 with respect to the fiscal year 1979;", and

(3) in paragraph (3)—

(A) by striking out "or" at the end of clause (D),

(B) by striking out the period at the end of clause (E) and inserting in lieu thereof "other than the fiscal year 1979, or", and

(C) by adding at the end thereof the following new subparagraph:

"(F) $3,300,000 with respect to the fiscal year 1979.".

Approved November 6, 1978.

LEGISLATIVE HISTORY:

HOUSE REPORTS: No. 95-1445 (Comm. on Ways and Means) and No. 95-1800 (Comm. of Conference).
SENATE REPORT No. 95-1263 (Comm. on Finance).
CONGRESSIONAL RECORD, Vol. 124 (1978):
Aug. 10, considered and passed House.
Oct. 5-7, 9, 10, considered and passed Senate, amended.
Oct. 15, Senate and House agreed to conference report.

○

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

House Report 95-1445

No material re social security in this report.

House Report 95-1445

No material re social security in this report.

Calendar No. 1187

95th Congress
2d Session

SENATE

Report
No. 95–1263

REVENUE ACT OF 1978

REPORT

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

together with

ADDITIONAL AND SUPPLEMENTAL VIEWS

ON

H.R. 13511

[Together with cost estimates of the
Congressional Budget Office]

October 1, 1978 (legislative day, September 28, 1978)
Filed under authority of the order of the Senate of September 28, 1978

U.S. GOVERNMENT PRINTING OFFICE
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Calendar No. 1187

95th Congress }
2d Session }
SENATE
{ Report
{ No. 95–1263

REVENUE ACT OF 1978

October 1 (legislative day, September 28), 1978.—Ordered to be printed
Filed under authority of the order of the Senate of September 28, 1978

Mr. Long, from the Committee on Finance,
submitted the following

REPORT

together with

ADDITIONAL AND SUPPLEMENTAL VIEWS

[To accompany H.R. 13511]

[Together with cost estimates of the Congressional Budget Office]

The Committee on Finance, to which was referred the bill (H.R. 13511) to amend the Internal Revenue Code of 1954 to reduce income taxes, and for other purposes, having considered same, reports favorably with an amendment and recommends that the bill as amended do pass.

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Section 2117 of the Tax Reform Act of 1976 (P.L. 94–455) provided that in the case of loans forgiven prior to January 1, 1979, no amount was to be included in gross income by reason of the discharge of all or part of the indebtedness of the individual under certain student loan programs. The exclusion applies to a discharge of indebtedness if the discharge was pursuant to a provision of the loan agreement under which all or part of the indebtedness would be discharged if the individual works for a certain period of time in certain professions in certain geographical areas or for certain classes of employers. The amendment made by the 1976 Act applies to student loans made to an individual to assist him in attending an educational institution only if the loan was made by the United States or an instrumentality or agency thereof or by a State or local government either directly or pursuant to an agreement with an educational institution.

Reasons for change

Many States and cities have experienced difficulty in attracting doctors, nurses, and teachers to serve certain areas, including both rural communities and low-income urban areas. A provision in student loan programs for loan cancellation in certain circumstances is intended to encourage the recipients, upon graduation, to perform needed services in such areas. The committee agrees with the proponents of these programs that the loan cancellation is not primarily for the benefit of the grantor, as the Service ruled in 1973, but for the benefit of the entire community. The committee believes that the exclusion from income of the amount of indebtedness discharged in exchange for these services would promote the purpose of the programs.

Explanation of provision

The provision extends to loans forgiven prior to January 1, 1983, the exclusion from income provided by the Tax Reform Act of 1976 with respect to cancellation of certain student loans. Accordingly, no amount shall be included in gross income by reason of the discharge of all or part of a student loan of the type described in section 2117 of the 1976 Act if the loan is forgiven prior to January 1, 1983.

There is no comparable provision in the House bill.

Effective date

The amendment applies with respect to loans forgiven prior to January 1, 1983.

Revenue effect

This provision will result in reduction of budget receipts of less than $5 million annually.

3. Employer educational assistance programs (sec. 163 of the bill and new sec. 124 of the Code)

Present law

Under present law, there is no provision for a specific exclusion from an individual's income for educational assistance provided by an employer. Thus, a determination as to whether an individual is required to include in income money or benefits furnished to assist him in his education generally is governed by sections 61 and 117 of the Code.

Section 61 provides that unless otherwise excluded by law gross income means all income from whatever source derived including, but not limited to, compensation for services. Under section 117, subject to certain qualifications, amounts received as scholarships at educational institutions and amounts received as fellowship grants are excluded from gross income.[1] The exclusion also covers incidental amounts received to cover expenses for travel, research, clerical help, and equipment when they are expended for these purposes.

The exclusion for scholarships and fellowship grants is restricted to educational grants by relatively disinterested grantors who do not require any significant consideration from the recipient.[2]

Under present law (Reg. § 1.162–5), educational expenditures made by an individual for his own education generally are deductible if they are for education that (1) maintains or improves skills required by the individual's employment or other trade or business, or (2) meets the express requirements of the individual's employer or the requirements of applicable law or regulations imposed as a condition to the retention by the individual of an established employment relationship, status, or rate of compensation. These types of education are commonly called "job-related education." However, no deduction is allowed for expenditures for education required of the individual in order to meet the minimum educational requirements for employment qualification in the individual's employment or other trade or business or for expenditures for education which is part of a program of study which will qualify the individual in a new trade or business. Such expenses may not be deducted even if the education maintains or improves skills required by the individual in the individual's employment or other trade or business or meets the express requirements of the individual's employer or applicable law or regulations. Nondeductible educational expenditures are personal expenses of the employee. Similarly, expenses which are incurred by an individual for recreation and which are not connected with a trade or business or the production of income, such as taking courses in connection with a hobby, are personal expenses of the individual and are not deductible. Thus, unless the educational expenses are deductible to the individual under the above rules, an employee ordinarily will have income which is not offset by deductions in the following situations:

(1) the employee is reimbursed for educational expenses by the employer;

(2) the employee's educational expenses are paid directly by the employer; or

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[1] To some extent, qualifications differ for individuals who are candidates for degrees and individuals who are not degree candidates. A degree candidate cannot exclude any amount to the extent it represents compensation for teaching, research, or other part-time services which the individual is required to render in order to obtain the grant unless such services are required of all candidates for a particular degree as a condition for receiving the degree.

In the case of a non-degree candidate, the exclusion is available only for up to $300 per month for no more than 36 months and then only if the grantor of the scholarship is a qualified governmental unit, charity, or international organization.

[2] *Bingler* v. *Johnson*, 394 U.S. 741 (1969).

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(3) the employer furnishes educational services directly to the employee.

An employer ordinarily can deduct amounts paid or incurred to provide educational assistance to employees because such amounts are treated as compensation under section 61.[3] However, such amounts may be nondeductible in some cases, for example, either as excessive compensation or as dividends, if the benefitted employees are shareholders.

Generally, unless specifically excluded by statute, all remuneration paid to employees, regardless of the form in which paid, constitutes wages subject to withholding of income and employment taxes. Remuneration is not necessarily excluded from the definition of employment tax wages for purposes of employment taxes and income tax withholding simply because it is excludible from gross income under some other section of the Code. However, Treasury regulations provide that certain advances and reimbursements paid to employees for ordinary and necessary business expenses are excluded from the definition of wages for withholding and employment tax purposes. Pursuant to these regulations, the Internal Revenue Service has ruled that educational expenses paid on behalf of, or reimbursed to, an employee for courses which maintain or improve skills required in employment, or meet express requirements of an employer as a condition to retaining employment, that is, job-related educational expenses, are excludable from the wages of the employee for purposes of employment taxes and income tax withholding. If the courses do not satisfy these tests, their cost is considered a personal expense of the employee and the advance or reimbursement is includible in wages and subject to employment taxes and withholding.[4]

Reasons for change

The committee believes that the treatment of employer-provided educational assistance under present law occasionally gives rise to inequitable administration, adds to the complexity of the tax system, and can act as a disincentive to continuing education, particularly among those at the lower end of the economic scale.

Because ambiguities exist in the "improve or maintain skills" test imposed under present law, the taxability of educational assistance programs of particular employers necessarily depends on IRS agents' case-by-case analyses of the skills needed for the jobs held by each employee participating in such programs.

The "job-related" distinction is often both ambiguous and restrictive. For example, if a person with little or no work experience is employed in an entry-level position and receives training from his employer to advance to a job requiring some greater skills or experience, the value of the training may be taxable. This may discourage self-improvement. If a typist, for example, receives training to be a secretary, or if a secretary receives training in a paralegal program, it might be considered not job-related. Also, if a clerical employee receives computer training, it may be treated as not job-related, even though the employee's job may require computer skills in the future because of normal advances in business technology.

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[3] In situations where an employer acquires items with a useful life in excess of one year and uses them for the direct furnishing of educational assistance to employees, the cost would have to be recovered through deductions for depreciation over the useful lives of such items. In other situations, the deductions would normally be allowed when the amount is paid or incurred (depending on the employer's method of accounting).

[4] See Treas. Reg. §§ 31.3121(a)-1(h), 31.3306(b)-1(h), and 31.3401(a)-1(b)(2); Rev. Ruls. 78-184, 1978-20 I.R.B. 19; 76-62, 1976-1 C.B. 12; 76-71, 1976-1 C.B. 308; and 76-352, 1976-2 C.B. 37.

However, the higher the level of job held by an employee, the greater the variety courses or training likely to qualify as related to the employee's job. The committee believes that the unfairness of this anomalous result should be eliminated.

The committee also intends to reduce to the complexity of present law in this area. Not only must the Internal Revenue Service use valuable personnel time in making determinations of taxability, but employees and employers also must justify their positions. The employer also must determine whether income tax withholding and employment taxes apply to reimbursement.

More serious even than the potential inequities of administration and the complexities of the tax law is the disincentive to upward mobility. Although most citizens recognize the need to provide greater access to educational and economic opportunity to those who have had limited access in the past, the tax law presently requires out-of-pocket tax payments for employer-provided educational assistance from those least able to pay, even though they receive only services, not an increased paycheck.

Therefore, the committee provides an exclusion for employer-provided educational assistance. To avoid abuse of this expanded tax-free treatment of educational assistance, the bill limits the exclusion to benefits provided to employees and provides antidiscrimination rules.

Explanation of provision

General

The provision excludes from an employee's gross income amounts paid for expenses incurred by the employer for educational assistance to the employee if such amounts are paid or such expenses are incurred pursuant to a program which meets certain requirements. In the case of education paid for, or furnished by, an individual's employer under such a program, the provision eliminates the need to distinguish job-related educational expenses from personal educational expenses for income tax purposes.[5]

Excludible benefits

The educational benefits which may be excluded from income are those furnished by an employer only to employees. The types of educational assistance which may be furnished are not restricted. The employer may provide educational assistance to the employee directly or the employer may reimburse the employee for the latter's expenses. Under the bill, an employee can exclude from income tuition, fees, and similar payments, as well as the cost of books, supplies, and equipment paid for, or provided by, his employer; however, the employee cannot exclude tools or supplies which the employer provides and which the employee may retain after completion of the course of instruction. Meals, lodging, or transportation also may not be excluded under this section. There is no restriction as to who may furnish the educational assistance. Such assistance may be furnished by an educational institution or any other party. Also, the employer, alone or in conjunction with other employers, may furnish the education directly to the employees. The education which may be furnished is not limited to job-related courses nor to courses which are part of a degree program. However, the exclusion does not apply to educational assistance furnished for courses involving sports, games, or hobbies, except where the education provided involves the business of the employer.

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[5] However, such a distinction still would have to be made in situations where the education is not excluded under this provision.

For a program to qualify under this provision, the employees must not be able to choose taxable benefits in lieu of the educational benefits.

A taxpayer may not claim any deducation, for example, a business expense deduction, nor may he claim any credit with respect to any amount which is excluded from his income under this provision. Thus, no double tax benefit can be obtained.

An employer educational assistance program is not required to be funded nor to be approved in advance by the Internal Revenue Service.

Nondiscrimination requirements

In order to be a qualified program, an educational assistance program also must meet requirements with respect to nondiscrimination in contributions or benefits and in eligibility for enrollment. The bill requires that a program must benefit employees who qualify under a classification set up by the employer and found by the Secretary not to be discriminatory in favor of employees who are officers, shareholders, self-employed individuals, highly compensated, or their dependents. The program must be available to a broad class of employees rather than to a particular individual. However, employees may be excluded from a program if they are members of a collective bargaining unit and there is evidence that educational assistance benefits were the subject of good faith bargaining between the unit and the employer or employers offering the program.

The bill specifically provides that a program shall not be considered discriminatory merely because it is utilized to a greater degree by one class of employees than by another class or because successful completion of a course, or attaining a particular course grade, is required for, or considered in, determining the availability of benefits.

Reasonable notification of the availability and terms of the program must be provided to eligible employees.

Operation

Under the bill, the exclusion does not apply if the program discriminates in favor of certain employees. A program is discriminatory if more than 5 percent of the benefits can be paid to shareholders, officers, highly compensated employees, self-employed individuals, or dependents of any of these groups.

Special rules

An individual who qualifies as an employee within the definition in section 401(c)(1) of the Code is also an employee for purposes of these provisions. Thus, in general, the term "self-employed individual" means, and the term "employee" includes, individuals who have earned income for a taxable year, as well as individuals who would have earned income except that their trades or businesses did not have net profits for a taxable year.

An individual who owns the entire interest in an unincorporated trade or business is treated as his own employer. A partnership is considered the employer of each partner who is also an employee of the partnership.

For determining stock ownership in corporations, the bill adopts the attribution rules provided under subsections (d) and (e) of section 1563 (without regard to sec. 1563(e)(3)(C)). The Treasury Department is to issue regulations for determining ownership interests in unincorporated trades or businesses, such as partnerships or proprietorships, following the principles governing the attribution of stock ownership.

The bill also provides that amounts excluded from income as educational assistance are not to be treated as wages subject to withholding of income nor as wages subject to employment taxes.

There is no comparable provision in the House bill.

Effective date

The bill applies to taxable years beginning after December 31, 1978.

Revenue effect

It is estimated that this provision will reduce calendar year liabilities by $23 million in 1979, $29 million in 1980, and $40 million in 1983. Budget receipts will be reduced by $18 million in fiscal year 1979, $28 million in fiscal year 1980, and $39 million in fiscal year 1983.

4. Tax counseling for the elderly (Sec. 164 of the bill)

Present law

Present law provides a number of specific tax benefits for elderly or retired individuals; however, it contains no provision dealing with tax counseling for the elderly. The Internal Revenue Service has, however, established a Volunteer Income Tax Assistance (VITA) program which provides individual taxpayer assistance through the use of Internal Revenue Service-trained volunteers.

Reasons for change

Preparation of a tax return is frequently a difficult task for the elderly. Upon reaching retirement age, taxpayers are often confronted with new provisions and complex forms. They often must complete a tax credit for the elderly schedule or a retirement income credit schedule, determine the taxable portion of retirement annuities, or compute the taxable gain when they sell their residences. For an untrained elderly individual, who has perhaps had no experience with the preparation of tax returns other than the short form 1040A, this change in circumstances may result in overpayment of tax. Alternacomputed as follows: (1) Assuming the CPI increased at a 7-percent rate in 1979 and 1980, the specified amount of $510 billion would be increased by 14.49 percent to $584 billion. (2) The excess of $600 billion over $584 billion is $16 billion. (3) Assume, for illustration, that calendar year 1981 corporate and individiual income tax liability were to be estimated by the Secretary at $280 billion. (4) The surcharge would be obtained by dividing $16 billion by $280 billion, which yields 5.7 percent which would be rounded up to 6 percent.

In order to deal with situations where outlays are different from those agreed to in the second budget resolution the secretary is given the authority to adjust the percentage whenever necessary, but not more than twice during any 12-month period, to compensate for errors of estimate or significant changes in Federal outlays or revenues not taken into account when the percentage was determined or previously adjusted.

The surtax is to apply to tax before credits rather than after credits. The surtax does not apply to certain taxes, including the minimum tax.

The surtax is to be suspended for any calendar year in which the unemployment rate (as determined by the Bureau of Labor Statistics) exceeds 7 percent for 3 months in a row or for any period during which a declaration of war is in effect.

The Secretary of the Treasury is directed to note on the Federal tax forms that this surtax is a result of growth in Federal spending in excess of 2 percent per year.

Effective date

This provision is to be effective upon enactment, but the surtax could not apply until calendar year 1980.

Revenue effect

This provision is not expected to yield any revenue because it is assumed that it would be a sufficiently effective deterrent to Federal spending increases that Congress would not trigger the tax.

O. Provisions Related to Social Security Act Programs

1. Fiscal relief for State and local welfare costs

(SECTION 601 OF THE BILL)

Present law

Increased welfare costs have imposed a difficult fiscal burden on States and localities in recent years. This has been particularly true in those areas that have tried to maintain adequate levels of benefits through their various social welfare programs, including aid to families with dependent children, supplemental security income, medicaid, social services and general assistance. Nationwide, there has been nearly a 50 percent increase in State and local expenditures for these programs in the last 5 years.

State and local expenditures for the AFDC program alone have increased from $3.4 billion in 1973 to an estimated $5.5 billion in 1978. In 1967, States and localities bore 42 percent of the cost of the AFDC program. Currently they are bearing 46 percent of the cost.

Each State's share of AFDC cash maintenance payments is determined by a formula which provides Federal matching of State payments at a rate of 50 to 83 percent, depending upon the State's per capita income. The following table shows the distribution of expenditures for AFDC payments for each State for 1976. Preliminary expenditure data provided by the Department of Health, Education, and Welfare indicate that, although overall expenditures for AFDC will show an increase for 1977, the proportions borne by States and localities will not be substantially different from 1976.

TABLE P-1.—AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC), TOTAL MAINTENANCE ASSISTANCE PAYMENTS, FISCAL YEAR 1976

State	Total payments computable for Federal funding	Federal funds (unadjusted)	Local funds	State funds	Percentage		
					Federal funds	Local funds	State funds
Alabama	$61,864,423	$46,923,718		$14,940,705	75.8	0	24.2
Alaska	13,457,182	6,623,664		6,833,518	49.2	0	50.8
Arizona	33,977,273	18,895,181		15,082,092	55.6	0	44.4
Arkansas	50,159,256	37,418,805		12,740,451	74.6	0	25.4
California	1,424,692,553	712,346,276	$253,580,487	458,765,790	50.0	17.8	32.2
Colorado	83,227,441	45,517,087	16,700,968	21,009,386	54.7	20.1	25.2
Connecticut	131,786,271	65,893,135		65,893,136	50.0	0	50.0
Delaware	23,649,023	11,824,511		11,824,512	50.0	0	50.0
District of Columbia	91,865,652	45,932,825		45,932,827	50.0	0	50.0
Florida	120,436,323	68,315,478		52,120,845	56.7	0	43.3
Georgia	122,679,985	90,120,035		32,559,950	73.5	0	26.5
Guam [1]	1,511,650	755,825		755,825	50.0	0	50.0
Hawaii	64,632,077	32,316,039		32,316,038	50.0	0	50.0
Idaho	19,796,706	13,497,394		6,299,312	68.2	0	31.8
Illinois	720,065,139	358,715,572		361,349,567	49.8	0	50.2
Indiana	115,583,003	66,425,552	20,351,153	28,806,298	57.5	17.6	24.9
Iowa	98,783,931	56,435,260		42,348,671	57.1	0	42.9
Kansas	67,602,756	36,519,009		31,083,747	54.0	0	46.0
Kentucky	132,730,945	94,730,076		38,000,869	71.4	0	28.6
Louisiana	98,429,037	71,272,467		27,156,570	72.4	0	27.6
Maine	46,662,236	32,943,539		13,718,697	70.6	0	29.4
Maryland	154,441,383	77,220,692	4,413,052	72,807,639	50.0	2.9	47.1
Massachusetts	415,121,135	207,560,568		207,560,567	50.0	0	50.0
Michigan	746,719,100	373,359,550		373,359,550	50.0	0	50.0
Minnesota	156,149,764	88,757,624	29,087,774	38,304,366	56.9	18.6	24.5
Mississippi	32,017,662	26,504,646		5,513,016	82.8	0	17.2
Missouri	140,017,934	85,774,453		54,243,481	61.3	0	38.7

Montana	12,786,884	8,082,589	1,008,552	3,695,743	63.2	7.9	28.9
Nebraska	28,780,341	15,998,096	...	12,782,245	55.6	0	44.4
Nevada	10,317,578	5,158,789	...	5,158,789	50.0	0	50.0
New Hampshire	23,673,490	14,270,380	6,700	9,396,410	60.2	...	39.7
New Jersey	426,793,857	213,396,928	52,226,857	161,170,072	50.0	12.2	37.8
New Mexico	32,125,612	23,544,860	...	8,580,752	73.3	0	26.7
New York	1,563,184,768	766,768,978	428,746,351	367,669,439	49.1	27.4	23.5
North Carolina	123,889,145	84,281,786	19,711,194	19,896,165	68.0	16.0	16.0
North Dakota	13,122,019	7,556,970	1,044,992	4,520,057	57.6	8.0	34.4
Ohio	446,319,654	242,753,261	...	203,566,393	54.4	0	45.6
Oklahoma	65,506,367	44,164,394	...	21,341,973	67.4	0	32.6
Oregon	113,521,471	67,023,078	1,165	46,497,228	59.0	...	41.0
Pennsylvania	650,945,260	360,558,579	...	290,386,681	55.4	0	44.6
Puerto Rico	24,171,922	12,085,960	...	12,085,962	50.0	0	50.0
Rhode Island	51,270,478	28,993,455	...	22,277,023	56.5	0	43.5
South Carolina	46,352,487	35,670,249	...	10,682,238	77.0	0	23.0
South Dakota	20,140,672	13,540,573	...	6,600,099	67.2	0	32.8
Tennessee	85,756,646	62,722,396	...	23,034,250	73.1	0	26.9
Texas	137,686,030	100,157,072	...	37,528,958	72.7	0	27.3
Utah	35,237,274	24,680,187	...	10,557,087	70.0	0	30.0
Vermont	26,538,100	18,528,902	...	8,009,198	70.0	0	30.0
Virgin Islands	1,849,649	924,824	...	924,825	50.0	0	50.0
Virginia	138,678,345	80,904,947	1,462,344	56,311,054	58.3	1.1	40.6
Washington	160,546,774	86,245,728	...	74,301,046	53.7	0	46.3
West Virginia	52,466,290	37,671,723	...	14,794,567	71.8	0	28.2
Wisconsin	210,875,774	126,335,680	...	84,540,094	59.9	0	40.1
Wyoming	4,900,181	2,986,169	684,505	1,229,507	60.9	14.0	25.1
Total	9,675,496,908	5,257,605,534	829,026,094	3,588,865,280	54.3	8.6	37.1

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[1] The sum of $755,825 was reported by Guam as a *local* expenditure; but is reported here as a *State* (territorial) expenditure. Adjustments have been made for errors in the printed report.

Source: Office of Financial Management. Division of Finance. Fiscal year 1976 State expenditures for public assistance programs approved under titles I, IV–A, X, IV, XVI, XIX, XX of the Social Security Act. (SRS) 77–04023. This report is compiled from State expenditure reports submitted quarterly by States.

The need to provide some relief for welfare costs now being borne at the State and local levels was recognized earlier by the 95th Congress when it approved $187 million in fiscal relief payments to States under the AFDC program for fiscal year 1978. This amount, which was agreed to by a House-Senate Conference as part of the Social Security Amendments of 1977 (P.L. 95–216) was half of the amount approved earlier by the Senate in its version of the 1977 Social Security Act amendments. The conferees agreed that the second half of the 1978 Senate fiscal relief amount would be considered as part of H.R. 7200, the Public Assistance Amendments of 1977. However, that bill has not yet been considered by the full Senate.

H.R. 7200, as reported by the Finance Committee, also included provision for up to $500 million in fiscal relief for States and localities for fiscal year 1979.

Committee provision

The committee believes that, although it may not be possible to act on all the provisions of H.R. 7200 this year because of insufficient time to consider its many important provisions, the issue of fiscal relief is an urgent one which should not be delayed until the next Congress. Thus the committee bill includes a provision for welfare fiscal relief for 1979 which is essentially the same as the provision which it approved last year as part of H.R. 7200.

The committee bill would make available an estimated $400 million in additional Federal funding for AFDC costs for 1979. This one-time provision would be payable as soon as possible after March 31, 1979. The payment would be based on an allocation of $500 million on the basis of a two-part formula. Half of the fiscal relief funds would be allocated to each State in proportion to its share of total expenditures under the program of aid to families with dependent children for December, 1976, and half would be allocated under the general revenue sharing formula.

To receive its full share of the payment, however, each State would have to demonstrate that it had reduced its payment error rate in the AFDC program to 4 percent or less as of the October, 1978-March, 1979 quality control sampling period. For purposes of this provision, the payment error rate would be calculated by considering excess payments made to recipients, that is, payments to ineligible individuals and overpayments to eligible persons. States which had not reached a 4-percent-or-less payment error rate by that period could still receive some payment depending on the degree of their progress toward that rate since a base period. At State option, the base period could be either the July–December, 1974 or January–June, 1975 quality control sampling period. If, for example, a State had a 10-percent error rate in the base period and had reduced that error rate to 8 percent as of October, 1978—March, 1979, the State would receive a payment equal to one-half of its full fiscal relief allocation since it had progressed one-half of the way toward the 4-percent goal. In any case, a State would receive at least 90 percent of its full allocation if its AFDC error rate for October, 1978—March, 1979 is 5 percent or less. A State would receive at least 75 percent of its full allocation if its error rate in that period is 6 percent or less.

The committee has long been concerned about weaknesses in administration of the AFDC program and about the very high error rates that have characterized AFDC payments in recent years. The committee recognizes that both the Administration and the States have been placing increasing emphasis on the need to improve the eligibility determination process, and that significant progress has been made in reducing errors under the AFDC program. The provision for relating State fiscal relief payments to improvements in quality control error rates is included as a way of rewarding those States that have already successfully reduced their error rates to low levels, and as an incentive to other States to make needed improvements. The provision emphasizes the committee's belief that improved AFDC administration should be a major concern of the Department of HEW, in order to assure that those persons who are most in need of help are indeed the persons who receive it.

In most States the cost of the non-Federal share of AFDC is borne entirely by the State. However, a number of States require substantial contribution by localities to the cost of the program. States reporting local contributions ranging from 1 to 27 percent of the cost of AFDC maintenance payments in fiscal year 1976 include: California, Colorado, Indiana, Maryland, Minnesota, Montana, New Jersey, New York, North Carolina, North Dakota, Virginia, and Wyoming. Localities in these States can expect to benefit from the provision in the committee bill which requires the States to pass the fiscal relief through to localities in any case where local governments pay part of the program's costs. However, States would not be required to pass through an amount in excess of 90 percent of the AFDC costs for which the local government was otherwise responsible. (It is intended that this amount paid to localities would be allocated among the various local jurisdictions in the State in proportion to each locality's share of AFDC costs.)

Although the fiscal relief provisions of the committee bill would be computed under a formula related in part to the AFDC program and would be provided to the States in the form of increased funding for that program, the committee wishes to make clear that it views these provisions as an attempt to provide some relief for the overall welfare burden faced by the States. That burden falls not only on the AFDC program but also in the areas of aid to the aged, blind, and disabled in States which supplement the SSI program, in medicaid and general assistance, and in programs of social and child welfare services.

Table P-2 shows how the fiscal relief payment under the bill would be distributed among the States.

TABLE P-2.—FISCAL RELIEF FOR WELFARE COSTS UNDER COMMITTEE BILL

[Dollars in thousands]

State	Percentage distribution	Unreduced allocation	Error rate in cash payments (percent) July–December 1974	Error rate in cash payments (percent) January–June 1975	Error rate in cash payments (percent) July–December 1977	Percent progress toward 4-percent error rate	Share of 1977 already achieved
Total	100.0	500,000					310,401
Alabama	1.1	$5,719	11.2	8.6	5.8	75.0	$4,289
Alaska	.2	1,184	11.2	9.4	12.8		
Arizona	.7	3,711	17.5	18.0	8.4	68.6	2,544
Arkansas	.7	3,660	5.3	6.7	9.3		
California	13.6	68,104	9.2	8.4	3.9	100.0	68,104
Colorado	.9	4,740	10.5	10.0	4.8	90.0	4,266
Connecticut	1.3	6,648	8.7	9.1	6.9	43.1	2,868
Delaware	.3	1,394	16.1	18.3	7.0	79.0	1,102
District of Columbia	.6	3,191	17.0	18.6	20.1		
Florida	2.1	10,655	16.2	12.7	6.1	82.8	8,821
Georgia	1.6	8,066	18.4	18.3	10.1	57.6	4,649
Hawaii	.6	3,025	11.4	13.4	10.1	35.1	1,062
Idaho	.3	1,428	4.9	6.0	2.7	100.0	1,428
Illinois	6.2	30,847	23.8	19.0	17.6	31.3	9,659
Indiana	1.6	7,814	6.7	4.5	2.0	100.0	7,814

Iowa	1.1	5,303	11.9	12.0	7.1	61.3	3,248
Kansas	.8	4,036	15.5	13.8	7.9	66.1	2,667
Kentucky	1.5	7,443	9.3	11.1	8.5	36.6	2,726
Louisiana	1.5	7,695	12.2	7.4	8.4	46.3	3,566
Maine	.6	2,825	11.7	16.4	9.0	59.7	1,686
Maryland	1.8	8,756	20.1	17.7	13.8	39.1	3,426
Massachusetts	3.8	18,966	17.9	19.8	11.7	51.3	9,723
Michigan	5.7	28,335	14.7	13.7	10.1	43.0	12,181
Minnesota	1.7	8,633	11.8	7.9	4.9	90.0	7,770
Mississippi	.9	4,428	5.3	5.3	9.3	......	......
Missouri	1.7	8,315	13.7	11.2	14.1	......	......
Montana	.3	1,273	14.4	21.7	8.8	72.9	928
Nebraska	.4	2,234	16.6	8.7	4.0	100.0	2,234
Nevada	.2	826	.4	.5	0	100.0	826
New Hampshire	.3	1,321	24.1	15.3	5.8	91.0	1,202
New Jersey	3.8	18,967	8.2	6.7	3.7	100.0	18,967
New Mexico	.5	2,273	6.3	6.0	4.9	90.0	1,384
New York	14.1	70,533	21.7	15.4	11.9	55.4	39,052
North Carolina	1.9	9,458	11.9	7.9	6.4	69.6	6,585
North Dakota	.2	990	2.0	.8	1.9	100.0	990
Ohio	4.2	20,987	15.9	17.7	10.8	50.4	10,570
Oklahoma	.9	4,339	3.5	3.5	4.6	90.0	3,905
Oregon	1.2	5,978	8.3	8.1	6.1	51.2	3,058
Pennsylvania	5.9	29,544	13.6	13.3	9.7	40.6	12,002
Rhode Island	.5	2,390	9.8	7.9	4.3	94.8	2,266

TABLE P-2.—FISCAL RELIEF FOR WELFARE COSTS UNDER COMMITTEE BILL—Continued

[Dollars in thousands]

State	Percentage distribution	Unreduced allocation	Error rate in cash payments (percent)			Percent progress toward 4-percent error rate	Share of 1977 already achieved
			July–December 1974	January–June 1975	July–December 1977		
South Carolina	0.9	$4,510	12.5	9.9	6.7	68.2	$3,078
South Dakota	.3	1,305	5.7	9.9	1.7	100.0	1,305
Tennessee	1.4	6,775	12.7	2.5	7.7	57.5	3,894
Texas	3.0	15,230	7.7	5.1	5.2	75.0	11,423
Utah	.5	2,408	8.4	10.6	3.8	100.0	2,408
Vermont	.3	1,268	7.9	9.2	6.3	55.8	707
Virginia	1.7	8,561	9.0	7.5	8.6	8.0	685
Washington	1.4	7,056	6.4	5.5	4.9	90.0	6,350
West Virginia	.7	3,349	5.5	4.5	4.9	90.0	3,014
Wisconsin	2.3	11,487	7.7	9.0	5.2	76.0	8,730
Wyoming	.1	501	11.9	9.0	7.6	54.4	327
American Samoa							
Guam	(*)	126					
Puerto Rico	.2	1,202	16.2	12.6	7.3	71.3	857
Virgin Islands	(*)	87	12.8	21.1	10.3	63.2	55

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*Less than 0.05 percent. Based on information supplied by the Department of Health, Education, and Welfare (AFDC data) and the Treasury Department (revenue sharing data).

2. Increase in Title XX Social Services ceiling

(SECTION 602 OF THE BILL)

Present law

In addition to providing Federal funding for cash public assistance to certain categories of needy individuals, the welfare titles of the Social Security Act have provided funding for a variety of social services programs. Originally, the costs of social services were considered a part of the administrative costs of operating cash public assistance programs, but subsequent amendments provided separate recognition of social services programs, expanded their availability to persons not receiving cash assistance, permitted funding of services provided by other than the welfare agency itself (including services by non-public agencies), and increased the Federal rate of matching to 75 percent (90 percent in the case of family planning services).

Prior to fiscal year 1973, Federal matching for social services, like Federal matching for welfare payments, was mandatory and open-ended. Every dollar a State spent for social services was matched by three Federal dollars. In 1971 and 1972 particularly, States made use of these provisions to increase at a rapid rate the amount of Federal money going into social services programs.

In 1972, the Congress established a $2.5 billion annual ceiling on the amount of Federal funding for social services programs effective for fiscal year 1973 and subsequent fiscal years. Under this overall national ceiling, each State has a ceiling established which is based on its population relative to the population of the entire Nation.

In 1974, Congress substantially revised the statutes governing the social services programs. The 1974 legislation transferred the provisions governing social services programs from the cash public assistance titles of the Social Security Act to a new separate services title (title XX). The Federal matching percentage for services remained at 75 percent under the new title XX program and the overall ceiling of $2.5 billion allocated among the States on a population basis was not changed.

The amount of the general title XX spending ceiling has not been increased since 1972. The only additional funding which has been available to the States for social services has been earmarked for child care services. The 94th and 95th Congresses authorized $200 million for child care for each of fiscal years 1977 and 1978.

Since the enactment of the Social Services Amendments in 1974, many States have undertaken to revise and strengthen their social services programs. Efforts have been made to expand the variety of services offered and to expand eligibility to a broader segment of the population. The result has been that although only 17 States were spending all or nearly all of their full allocation under title XX in 1975, 41 States are at or near their spending ceiling at the present time. The following table shows the number of States using less than their full allocation under title XX.

TABLE P-3.—NUMBER OF STATES USING LESS THAN FULL AVAILABLE TITLE XX FUNDING UNDER $2.5 BILLION CEILING, 1975-79

[Number of States]

Fiscal year	98 to 100 percent of ceiling	90 to 98 percent of ceiling	80 to 90 percent of ceiling	Less than 80 percent of ceiling	Federal cost (000)
1975	12	5	5	29	$1,962,581
1976	18	7	9	17	2,130,380
1977 [1]	19	14	9	9	2,259,726
1978 [1]	35	6	6	4	2,382,604
1979 [1]	48	1	1	1	2,450,000

[1] Estimated.

Source: Fiscal 1979 budget estimates, Department of Health, Education, and Welfare.

The law allows each State to decide the kinds of services it wishes to provide. It is estimated that child care services will consume about 22 percent of Federal title XX funds in 1979. Other major services provided are homemaker/chore services and services involving education, training and employment. Although States vary widely in the way they spend their social services funds, the following table shows how funds are expected to be spent in 1979 for the Nation as a whole.

TABLE P-4.—TITLE XX SERVICES: ESTIMATED DISTRIBUTION OF FEDERAL FUNDING BY TYPE OF SERVICES AND NUMBER OF RECIPIENTS, FISCAL 1979

[In thousands]

Type of service	Number of recipients	Federal funding	
		Amount	Percent
Total	(1)	$2,650,000	100.0
Child day care	649	580,350	21.9
Homemaker/chore	411	302,100	11.4
Education, training and employment	511	272,950	10.3
Protective services	723	262,350	9.9
Child foster care	327	222,600	8.4
Counseling	642	185,500	7.0
Health-related services	804	127,200	4.8
Residential care	123	95,400	3.6
Family planning	312	63,600	2.4
Other	(2)	537,950	20.3

[1] Number of recipients is not additive as recipients may receive more than 1 type of service.

[2] Not estimated.

Source: Fiscal 1979 budget estimates, Department of Health, Education, and Welfare.

Committee provision

The committee believes that in order to assure that States can continue to offer their current level of services in this period of high inflation, the overall ceiling on spending for title XX should be adjusted to take into account the increase in the cost of living that has taken place in the last year. Based on the $2.7 billion amount available to the States for fiscal year 1978, this adjustment requires an increase of approximately $200 million. The committee bill therefore provides an overall ceiling for 1979 of $2.9 billion. As under the temporary provisions of Public Law 94-401, however, $200 million will be earmarked for child care services and will be allocated to the States on the basis of State population, using the regular title XX distribution formula. These funds will be available to the States for child care on a 100 percent Federal funding basis. The current Federal matching rate of 75 percent (90 percent for family planning) will continue for the other $2.7 billion of title XX funds.

The following table shows how the funds made available under the committee's bill would be allocated.

TABLE P-5.—ALLOCATION OF 1979 TITLE XX FUNDS UNDER THE COMMITTEE BILL

State	Allocation of $2.9 billion	Amount of allocation earmarked for child care
Alabama	49,524,000	3,415,000
Alaska	5,162,000	356,000
Arizona	30,674,000	2,115,000
Arkansas	28,498,000	1,965,000
California	290,790,000	20,054,000
Colorado	34,903,000	2,407,000
Connecticut	42,119,000	2,905,000
Delaware	7,864,000	542,000
District of Columbia	9,486,000	654,000
Florida	113,789,000	7,848,000
Georgia	67,158,000	4,632,000
Hawaii	11,986,000	827,000
Idaho	11,229,000	774,000
Illinois	151,733,000	10,464,000
Indiana	71,644,000	4,941,000
Iowa	38,781,000	2,675,000
Kansas	31,214,000	2,153,000
Kentucky	46,321,000	3,195,000
Louisiana	51,902,000	3,579,000
Maine	14,458,000	997,000

TABLE P-5.—ALLOCATION OF 1979 TITLE XX FUNDS UNDER THE COMMITTEE BILL—Continued

State	Allocation of $2.9 billion	Amount of allocation earmarked for child care
Maryland	55,996,000	3,862,000
Massachusetts	78,494,000	5,413,000
Michigan	123,018,000	8,484,000
Minnesota	53,577,000	3,695,000
Mississippi	31,809,000	2,194,000
Missouri	64,563,000	4,453,000
Montana	10,175,000	702,000
Nebraska	20,985,000	1,447,000
Nevada	8,243,000	569,000
New Hampshire	11,107,000	766,000
New Jersey	99,128,000	6,836,000
New Mexico	15,783,000	1,089,000
New York	244,361,000	16,852,000
North Carolina	73,900,000	5,097,000
North Dakota	8,689,000	599,000
Ohio	143,869,000	9,922,000
Oklahoma	37,376,000	2,578,000
Oregon	31,471,000	2,170,000
Pennsylvania	160,286,000	11,054,000
Rhode Island	12,526,000	864,000
South Carolina	38,484,000	2,654,000
South Dakota	9,270,000	639,000
Tennessee	56,942,000	3,927,000
Texas	168,731,000	11,637,000
Utah	16,593,000	1,144,000
Vermont	6,432,000	444,000
Virginia	67,995,000	4,689,000
Washington	48,807,000	3,366,000
West Virginia	24,606,000	1,697,000
Wisconsin	62,279,000	4,295,000
Wyoming	5,270,000	364,000

Source: Department of Health, Education, and Welfare.

The committee bill would also provide States with additional flexibility in planning their social services programs. Present law requires that States develop annual plans describing how funds are to be used and who will be eligible for services. The planning process required in law provides for publication by the State of a proposed plan and for a period during which public comment must be accepted. Federal regulations place additional requirements on the States for consultation with various parties involved in social services programs either as providers or as consumers.

After several years experience with the annual planning process, a number of States have concluded that their planning could best be done on a multi-year basis. In its proposed social services amendments this year the Administration recommended that States be allowed to develop plans for up to 3 years. The committee agrees that it is desirable to allow States to develop plans over a longer period of time, according to their needs, and therefore has provided that States may use a 1, 2, or 3-year planning process. As under present law, State plans could be amended at any time.

In addition, the committee has been informed that some States are hindered in coordinating their social services programs by the requirement in present law that they use either the Federal or State fiscal year for their title XX services' program year. The committee bill would give these States added flexibility by allowing them also the choice of using the county fiscal year. Within any one State, however, the planning period would have to be a single period of either 12, 24, or 36 months.

3. Management Information System

(SECTION 603 OF THE BILL)

Present law

There is increasing evidence that administration of the AFDC program could be significantly improved if States establish and use computerized information systems in the management of their programs. Such systems have been demonstrated to be helpful in program planning and evaluation. They also make day-to-day operations more efficient, and they are crucial to assuring that eligibility determinations are properly made and that fraud and abuse are discovered on a timely and ongoing basis. Although the merits of such systems are generally recognized, the States have been slow to develop them because of the large initial outlays which are necessary, and because of the ongoing cost of operating them. States may currently receive Federal matching for the systems as an administrative cost, but Federal matching is limited to 50 percent. This is in contrast to the medicaid program, in which 90 percent Federal matching is authorized for the cost of developing and implementing computer systems, and 75 percent for their operation.

Committee provision

The committee is convinced that the administration of State AFDC programs could be greatly improved through judicious use of modern computerized management information systems. Recipients could be expected to benefit from more expeditious handling of their cases and decreases in processing time; local, State, and Federal Governments—and the taxpayer—could be expected to benefit from a decrease in costs because of a reduction in errors and use of better planning and management techniques.

carefully study this issue. The Congress should not adopt a quick fix-up without careful consideration.

Conclusion

Finally, there are some provisions in this bill which I do not support. Particularly, I am concerned that the Committee agreed to raise the maximum amount of the earned income credit to $600 from $400 and to extend eligibility to $11,000 of income.

The American taxpayer needs and deserves a tax break. The American economy needs tax reduction and new capital for business expansion. The Finance Committee, to a limited extent, accomplished these goals.

Provisions related to Social Security Act Programs

Section 601 of the bill provides for a one-time fiscal relief payment to the States designed to help meet State and local welfare costs. The payment would be based on improvement in State welfare error rates through March 1979. Since the formula used would be based on quality control reports made under existing regulations, the provision would also have no significant regulatory impact.

Section 602 of the bill modifies the title XX social services program primarily by providing an increased level of Federal funding. Also included in this section, however, are amendments to the State planning requirements which should give States added flexibility and thus lessen somewhat the regulatory impact of the program.

Sections 603–606 of the bill contain a number of amendments designed to improve the operations of the aid to families with dependent children (AFDC) program and the related child support program. The AFDC program is a State-operated assistance program which receives Federal matching funds through title IV of the Social Security Act. As of March 1978, 10.9 million individuals were recipients of benefits under this program. The regulatory impact of the provisions in these sections of the bill are largely confined to these individuals and the State and local welfare agencies which administer the program and their employees. In general these sections provide additional Federal support to the States in the attempt to strengthen the administration of these programs. The regulatory impact would be minimal and would be largely confined to the necessary assurances that the added Federal aid was properly utilized.

Sections 607 and 608 increase Federal funding for public assistance programs in Guam, the Virgin Islands, and Puerto Rico. Apart from regulations implementing the increased funding, no regulatory impact should result from these provisions. Section 609 extends to the Northern Marianas the welfare programs now applicable to the other territories. This would require HEW regulations to become applicable to that jurisdiction in the same manner as they are applicable to the other territories.

B. Vote of the Committee

In compliance with section 133 of the Legislative Reorganization Act of 1946, the following statement is made relative to the vote by the committee on the motion to report the bill. H.R. 5263, as amended by the committee, was ordered favorably reported by the following rollcall vote: In favor (15): Messrs. Long, Talmadge, Ribicoff, Byrd (Va.), Gravel, Bentsen, Hathaway, Matsunaga, Moynihan, Curtis, Hansen, Dole, Packwood, Laxalt, and Danforth; Opposed (3): Nelson, Haskell and Roth.

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95th Congress
2d Session

HOUSE OF REPRESENTATIVES

Report
No. 95-1800

Revenue Act of 1978

October 15 (legislative day, October 14), 1978--Ordered to be printed

Mr. Ullman, from the committee of conference, submitted the following

CONFERENCE REPORT

(To accompany H.R. 13511)

VIII. PROVISIONS RELATING TO SOCIAL SECURITY ACT PROGRAMS

118. Title XX Social Services Programs

a. Ceiling on Federal title XX funds

House bill.—No provision.

Senate amendment.—Under existing law there is a permanent annual ceiling of $2.5 billion on Federal matching funds for the state Title XX social services programs. Since October 1, 1976 an additional $200 million of Federal Title XX funds has been available to states on a non-matching basis. To qualify for their portion of the $200 million states have to spend for day care under Title XX an amount equal to their additional allotment under the temporary $200 million. Authority for this $200 million expired September 30, 1978.

The Senate amendment increases the permanent ceiling to $2.9 billion beginning with fiscal year 1979. $200 million of the Title XX funds would be designated for child care services with no state matching requirement in Fiscal year 1979.

Conference agreement.—The conference agreement follows the Senate amendment except that the increase in the ceiling to $2.9 billion is for one year only (fiscal year 1979). After 1979, the ceiling reverts to $2.5 billion.

b. Multiyear planning program

House bill.—No provision.

Senate amendment.—Present law requires states to develop an annual services plan for the title XX program in the state. The Senate amendment provides the option for a state to establish either a one, two or three year Title XX program period.

Conference agreement.—The conference agreement does not include this provision.

c. Program year used by States

House bill.—No provision.

Senate amendment.—Under present law states must use either the Federal or state fiscal year as their program year for their Title XX social services program year. The Senate amendment would also give states the option to establish their social services program plans according to the fiscal year which applies to counties in the state.

Conference agreement.—The conference agreement does not include this provision.

119. AFDC management information system

House bill.—No provision.

Senate amendment.—Present law provides that states receive 50 percent Federal matching for the cost of administering their AFDC programs. The Senate amendment provides 90 percent Federal matching to states for the costs of developing and implementing computerized AFDC management information systems and 75 percent for the cost of their operation. HEW would be required to approve state systems as a condition of Federal matching (both initially and on a continuing basis). A state system would have to include certain specified characteristics, including ability to provide data on AFDC eligibility factors, capacity for verification of factors with other agencies, capability for notifying child support, food stamps, social services and Medicaid programs of changes in AFDC eligibility and benefit amount, compatibility with systems in other jurisdictions, and security against unauthorized access to or use of data in the system. HEW would be required to provide technical assistance to the states. Increased matching would be payable for quarters beginning January 1, 1979.

Conference agreement.—The conference agreement does not include this provision.

120. Amendments to AFDC employment requirements under WIN program

a. Employment search requirement

House bill.—No provision.

Senate amendment.—Present law provides that AFDC recipients who are not specifically exempt are required to register for manpower services, training and employment as a condition of AFDC eligibility. The Senate amendment adds "other employment related activities" to the types of activities for which recipients must register. Requires that necessary social and supportive services be provided during employment search.

Conference agreement.—The conference agreement does not include this provision.

b. Termination of assistance

House bill.—No provision.

Senate amendment.—Present law provides assistance is to be terminated for so long as an individual (who has been certified by the welfare agency as ready for employment or training) refuses without good cause to participate in WIN. There is a 60 day counseling period during which assistance may not be terminated despite an individual's refusal to participate in WIN so long as the individual accepts counseling and other services aimed at persuading the individual to participate in a WIN program.

The Senate amendment eliminates provision for the 60 day counseling period. It also authorizes the Secretaries of Labor and HEW to establish by regulation the period of time during which an individual will not be eligible for assistance in the case of refusal without good cause to participate in a WIN program.

Conference agreement.—The conference agreement does not include this provision.

c. Support units

House bill.—No provision.

Senate amendment.—Present law requires states to have special units to provide social and supportive services to enable WIN registrants to engage in seeking and retaining employment.

The Senate amendment requires that these special units be colocated with the WIN manpower units to the maximum extent feasible.

Conference agreement.—The conference agreement does not include this provision.

d. State matching funds

House bill.—No provision.

Senate amendment.—Present law provides that states must provide 10% of the cost of the WIN program. Matching for manpower activities may be in cash or in-kind, but matching for the supportive services must be in cash.

The Senate amendment would allow state matching for the supportive services to be in cash or in-kind.

Conference agreement.—The conference agreement does not include this provision.

e. Treatment of public service employment earnings

House bill.—No provision.

Senate amendment.—Current law makes it unclear whether income from public service employment is excluded in determining AFDC benefits.

The Senate amendment clarifies that income from public service employment is not excluded in determining AFDC benefits.

Conference agreement.—The conference agreement does not include this provision.

f. Individuals exempt from WIN

House bill.—No provision.

Senate amendment.—Present law provides that certain categories of AFDC recipients are exempted from the WIN registration requirement, including children under 16; persons caring for a child under 6; persons who are ill or needed as caretaker of someone in the home who is ill; or persons who are remote from a WIN project.

The Sentate amendment adds to the individuals who are exempted from registration for WIN individuals who are working at least 30 hours a week.

Conference agreement.—The conference agreement does not include this provision.

121. Incentive for AFDC recipients to report earnings

House bill.—No provision.

Senate amendment.—Present law requires AFDC recipients to report earnings to the welfare agency. There is provision for disregarding portions of earned income in determining eligibility for and amount of the AFDC payment. When unreported earnings resulting in overpayments are discovered, the earned income disregards are applied to the unreported earnings in calculating the amount of the overpayment.

The Senate amendment provides that, if a recipient fails without good cause to make a timely report of earnings, the recipient would not have the benefit of having the earned income disregards applied to such unreported earnings.

Conference agreement.—The conference agreement does not include this provision.

122. Matching for child support costs of court personnel

House bill.—No provision.

Senate amendment.—Under present law State plans under the Title IV-D child support enforcement program must provide for entering into cooperative arrangements with appropriate courts and law enforcement officials to assist the child support agency in administering the program. The law provides or entering into financial arrangements with courts and officials. HEW regulations prohibit Federal matching for salaries of judges and their support staff.

The Senate amendment authorizes matching for compensation for judges and other support and administrative personnel of courts who performed Title IV-D functions, but only for those functions, specifically identifiable as IV-D functions. Matching would be provided only for expenditures in excess of levels of spending in the state for these activities in 1976.

Conference agreement.—The conference agreement does not include this provision.

123. Increase in Federal funding for territorial assistance programs

House bill.—No provision.

Senate amendment.—Under present law, public assistance programs in Puerto Rico, Guam and the Virgin Islands qualify for Federal matching at a 50 percent rate and are subject to dollar limits on the amount of Federal funding available. The annual limit is $24 million for Puerto Rico, $800,000 for the Virgin Islands and $1.1 million for Guam.

The Senate amendment would increase the Federal matching rate for public assistance programs (aid to the aged, blind and disabled and AFDC) to 75 percent and would triple the maximum annual amount of Federal funding to $72 million for Puerto Rico, $2.4 million for the Virgin Islands, and $3.3 million for Guam.

Conference agreement.—The conference agreement follows the Senate amendment, except that the increase in the matching rate and ceilings is effective only for one year—fiscal year 1979.

124. Northern Mariana Island provisions

House bill.—No provision.

Senate amendment.—In present law, the covenant establishing the Commonwealth of the Northern Marianas specifically extended the supplemental security income (SSI) program to that jurisdiction and implicitly extends other public assistance programs. Statutory provisions do not specifically include the Marianas under any Social Security Act programs.

The Senate amendment provides for bringing the Mariana Commonwealth under the Social Security Act public assistance programs in a manner compatible to the other territories. This would allow the Commonwealth to provide assistance and social services under state plan programs of the aged, blind and disabled and aid to families with dependent children. Coverage under the medical assistance (Medicaid) program would also be provided. Under the Senate amendment, the SSI program would no longer be applicable in the Marianas.

Conference agreement.—The conference agreement does not include this provision.

125. Foster care, adoption assistance and child welfare services

a. Ceiling on Federal AFDC foster care funds

House bill.—No provision.

Senate amendment.—Under present law Title IV–A authorized open-ended Federal matching for use by states to provide foster care payments for the care of children who (1) meet the state AFDC eligibility requiremens and (2) have been removed from their homes as the result of judicial determination. Federal matching rate is the same as for AFDC income maintenance payments.

The Senate amendment creates a new Part E of Title IV "Federal Payments for Adoption Assistance and Foster Care" and amends the child welfare services program. It also establishes a ceiling on Federal foster care funding. The state's fiscal year 1978 expenditures of Federal funds for foster care would be the base and the allotment for each state could not exceed an additional 20 percent in 1979 and 10 percent per year in each of the next 4 years. To provide room for growth in states with small programs an alternative ceiling would be provided equal to each state's share of $100 million based on state population under age 21. States that did not use their full allotment for foster care could use excess funds for IV–B child welfare services.

Conference agreement.—The conference agreement does not include this provision.

b. Foster care provided in institutions

House bill.—No provision.

Senate amendment.—Present law provides that Federal foster care matching funds are available for foster care provided in institutions only in the case of nonprofit private institutions.

The Senate amendment allows funding of foster care maintenance payments for children in public facilities, but only if the public institution serves no more than 25 children. Funding would not be available for children in such institutions prior to enactment of these provisions.

Conference agreement.—The conference agreement does not include this provision.

c. Adoption assistance

House bill.—No provision.

Senate amendment.—Under present law Federal AFDC matching funds are not available for adoption subsidies.

The Senate amendment authorizes states to make assistance payments to parents who adopt "hard-to-place" children. The matching rate would be the same as under the AFDC program. States would have to find that the child would have been receiving AFDC but for the child's removal from the home of his relatives; that the child cannot be returned to that home; and that after making a reasonable effort consistent with the child's needs, the child has not been adopted without offering of financial assistance. The determination of whether a child is difficult to place would have to be made by the state based on a specific fact or condition because of which it is reasonable to conclude that the child cannot be adopted without adoption assistance.

Families would be eligible for an adoption subsidy so long as their income does not exceed 115 percent of the median family income for a family of four in the state, adjusted to reflect family size. The amount of the subsidy would be agreed on by the family and the agency but could not exceed the amount paid for foster care (in a foster family home) and would be terminated when the child reached 18 or the family's income exceeded the specified limits. A child with a medical disability that existed at the time of adoption would continue to be covered under medicaid for treatment related to that medical disability. States would be permitted to make an adopted child with a pre-existing medical condition eligible for treatment under medicaid for other medical conditions as well. Matching for adoption subsidies would not be provided for adoption agreements entered into after January 1, 1983.

Conference agreement.—The conference agreement does not include this provision.

d. Federal funds for child welfare services

House bill.—No provision.

Senate amendment.—Present law authorizes $266 million (of which $56.5 million was appropriated for fiscal year 1978) in Federal matching funds to be alloted to the States for a wide range of child welfare services and for foster care payments. The theoretical Federal matching rate ranges from 33⅓ to 66⅔ percent. There are no prohibitions on the use of funds for foster care maintenance payments.

The Senate amendment retains the present law authorization of up to $266 million for child welfare services, but increases the Federal matching to 75 percent, and provides that funds appropriated in future years that are above the amount appropriated for fiscal year 1978 ($56.5 million) may not be used for foster care maintenance payments.

Conference agreement.—The conference agreement does not include this provision.

e. Foster care protections

House bill.—No provision.

Senate amendment.—There is no provision in present law. The Senate amendment permits States to use child welfare service funds for State tracking and information systems, individual case review systems, services to reunite families or place children in adoption, and procedures to protect the rights of natural parents, children and foster parents. The amendment allows the Congress to designate that any new funding be specifically used for these purposes. In the first year for which a State receives funds for these purposes it would be allowed to use them to conduct an inventory of children who have been in foster care for 6 months preceding the inventory, and to design and develop a statewide information system for children in foster care, a case review system for each child, and a service program designed to help children remain with their families.

Conference agreement.—The conference agreement does not include this provision.

126. AFDC earned income disregard

House bill.—No provision.

Senate amendment.—Under present law, in determining the amount of benefits to be paid to an AFDC recipient with earnings the following formula is used: Disregard (1) $30 a month in earnings, (2) one-third of remaining earnings, and (3) the amount of work related expenses.

The Senate amendment provides for disregarding from earned income (1) an amount equal to reasonable child care expenses (subject to limitation prescribed by HEW), (2) from the remaining income $60 a month in the case of an individual working full time and $30 in the case of an individual working part-time (3) one-third of the next $300 of monthly earnings, and (4) one-fifth of the remaining earnings.

Conference agreement.—The conference agreement does not include this provision.

Finder's Aid

P.L. 95-626 (92 Stat. 3551) Approved November 10, 1978
Health Services and Centers Amendments of 1978

Subject	SS Act Section	P.L. Section	92 Stat.	H.Rep. 95-1191	S.Rep. 95-860	H.C.Rep. 95-1799
Redesignating Migrant Health Center Provision (Technical Amendment)	1903(m)(2)(B)(i)	102(b)(3)	3551	37-38	26-27	2

ublic Law 95-626
5th Congress

An Act

o amend the Public Health Service Act and related health laws to revise and extend the programs of financial assistance for the delivery of health services, the provision of preventive health services, and for other purposes.

Nov. 10, 1978
[S. 2474]

Be it enacted by the Senate and House of Representatives of the nited States of America in Congress assembled,

Health Services and Centers Amendments of 1978.
42 USC 201 note.

SHORT TITLE; REFERENCE TO ACT

SECTION 1. (a) This Act may be cited as the "Health Services and Centers Amendments of 1978".

(b) Except as otherwise specifically provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Public Health Service Act.

42 USC 201 note.

TITLE I—HEALTH CENTERS AND PRIMARY HEALTH CARE

PART A—MIGRANT HEALTH CENTERS AND COMMUNITY HEALTH CENTERS

Migrant and Community Health Centers Amendments of 1978.
42 USC 201 note.
42 USC 247d.

SHORT TITLE

SEC. 101. This part may be cited as the "Migrant and Community Health Centers Amendments of 1978".

REDESIGNATION OF MIGRANT HEALTH CENTERS PROVISION

42 USC 254b.

SEC. 102. (a) Section 319 is redesignated as section 329 and is transferred and inserted before section 330.

42 USC 218.

(b)(1) Section 217(g) is amended by striking out "319" and inserting in lieu thereof "329" each place it appears.

42 USC 300e-14a.

(2) Section 6(b) of the Health Maintenance Organization Act of 1973 (Public Law 93-222) is amended by striking out "310" and inserting in lieu thereof "329".

42 USC 1396b.

(3) Section 1903(m)(2)(B)(i) of the Social Security Act is amended by striking out "section 319(d)(1)(A)" and inserting in lieu thereof "section 329(d)(1)(A)".

AMENDMENTS TO MIGRANT HEALTH CENTERS PROGRAM

Supra.

SEC. 103. (a)(1)(A) Paragraph (1) of subsection (a) of section 329 (as redesignated by section 102(a) of this part) is amended by inserting "(as determined by the centers)" after "as may be appropriate for particular centers" in subparagraphs (D) and (E).

TITLE VIII—STUDY OF ADOLESCENT PREGNANCY

Contract authority. 42 USC 300a-21 note.

SEC. 801. (a) The Secretary of Health, Education, and Welfare shall contract with an independent entity to perform a study of the problem of adolescent pregnancies. The study shall evaluate the effectiveness of existing programs relating to health, education, and public welfare, as they relate to this problem, and shall include suggestions as to the most effective means for reducing or eliminating unwanted adolescent pregnancies. The Secretary shall report the results of such study to the Congress not later than one year after the date of the enactment of this Act.

Report to Congress.

Appropriation authorization.

(b) There are authorized to be appropriated such sums, not to exceed $500,000, as may be necessary to carry out the provisions of this section.

Approved November 10, 1978.

LEGISLATIVE HISTORY:

HOUSE REPORTS: No. 95-1191 accompanying H.R. 12370 (Comm. on Interstate and Foreign Commerce) and No. 95-1799 (Comm. of Conference).

SENATE REPORT No. 95-860 (Comm. on Human Resources).

CONGRESSIONAL RECORD, Vol. 124 (1978):

Sept. 25, H.R. 12370 considered and failed of passage in House.

Sept. 29, considered and passed Senate.

Oct. 11, 13, H.R. 12370 considered and passed House; passage vacated, and S. 2474, amended, passed in lieu.

Oct. 15, Senate and House agreed to conference report.

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95th Congress } HOUSE OF REPRESENTATIVES { Report
2d Session } { No. 95-1191

HEALTH SERVICES AMENDMENTS OF 1978

REPORT

BY THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

[To accompany H.R. 12370]

together with

SEPARATE VIEWS

[Including Cost Estimate of the Congressional Budget Office]

May 15, 1978.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON : 1978

and public education, and are working in areas of social and behavioral sciences and genetic counselling as well. Outreach programs are also being developed so that, according to testimony before the Subcommittee, five Northeastern Area centers are providing services in nine States.

PROPOSED LEGISLATION

The proposed legislation would continue for three fiscal years, with no statutory changes, the authorities for programs of hemophilia treatment centers and blood separation centers. The Committee is pleased with the apparent progress of the centers and wishes to assure the continued availability of blood products necessary for the treatment of the hemophiliac.

VIII. HOME HEALTH SERVICES (CURRENTLY SECTION 602 OF PUBLIC LAW 94–63; PROPOSED TO BE A NEW SECTION 312 OF THE PUBLIC HEALTH SERVICE ACT)

BACKGROUND

Over the past few years, as hospital and nursing home costs have spiraled upward, much attention has been given to the search for alternative modes of care. Home health care has been increasingly recognized as providing, in many instances, a less expensive and often more effective alternative to continuing hospital and nursing home care. In addition to any cost savings involved, there is the psychological advantage to most patients who would prefer to remain in their own home for as long as possible, rather than to receive institutional care.

A report prepared for the Senate Special Committee on Aging in July 1973 ("Home Health Services in the United States: A Working Paper on Current Status"), summarized the benefits of effective home health care programs as follows:

1. Patients prefer care that can be provided in the normalcy of their home environment.
2. Home-bound people can be taught to live relatively independently.
3. The need for initial admission or readmission to in-patient institutions can be diminished.
4. For the necessary institutional admission, unnecessary days can be eliminated through early discharge to home care.
5. Capital construction costs for inpatient facilities can be reduced.
6. The efficiency of the practicing physician can be increased by expanding the team approach. The physician can care for a greater number of patients through a home care program because he does not have to assemble and individually coordinate the services needed for his patients in their home settings.
7. Home care staff can readily interpret medical orders, explain treatment regimes, and offer reassurance and support.
8. Home care staff can identify day-to-day problems and thus help to reduce the possibility of emergency situations arising.

In part, the large increase in home health agencies in the early years of Medicare was due to the availability of a new source of reimbursement which encouraged many communities to create home health care providers. The increase also resulted from the availability of Federal formula grants in 1966 and 1967 which provided almost $16 million to State health departments for the creation or expansion of public and private nonprofit home health agencies. The Partnership for Health Amendments in 1967 (Public Law 89–749) integrated the home health grant program into the 314(d) formula grant; most States decided not to direct any portion of their limited noncategorical funds into home health services.

While the enactment of the Medicare and Medicaid legislation gave impetus to the establishment of home health agencies, reimbursement for home health services available under these programs does not provide an adequate mechanism for creating resources. Payments from these two programs are made only to agencies which have been certified as meeting the standards for participation established by the programs and only after covered services have been rendered to the patients. Medicare and Medicaid funds, therefore, are not available to assist in initiating services by a new agency and only moderately useful in assisting in the expansion of services.

The Health Revenue Sharing and Health Services Act of 1975 (Public Law 94–63) authorized demonstration grants for the initial costs of establishing and operating home health services agencies in areas in which such services were not then available and for the expansion of services provided by existing agencies. It also authorized demonstration grants for training professional and paraprofessional personnel in the provision of home health care. The program was extended for fiscal year 1977 under the Health Maintenance Organization Amendments of 1976 (Public Law 94–460), and for fiscal year 1978 under Public Law 95–83.

The home health grant program has reduced the number of counties in the United States which are not served by home health care services. During the first two years of the program, 92 counties were able to avail themselves of this new program support to establish their first home health agencies.

PROPOSED LEGISLATION

The proposed legislation would move the home health services program intact into a new section 312 of the Public Health Service Act. The effect of this change would be to formally place his grant program under the review process established by the National Health Planning and Resource Development Act of 1974. In fact, Departmental regulations have already included home health programs authorized in this section to be given such review. The fiscal year 1978 authorization for home health demonstration projects was $8 million; the appropriation $5 million. The fiscal year 1978 authorization for home health training was $4 million; the appropriation $1 million. For fiscal year 1979 the demonstration authorization is $14 million and the training authorization is $2 million.

The Committee is aware that there are still in excess of 600 counties without formal home health care programs; however, these are essentially sparsely populated areas. Accordingly, the Committee intends for funds appropriated under this title to be used primarily to strengthen and expand existing service programs where such expansion is warranted based on actual community need.

[In millions]

	1978	1979	1980	1981
Planning grants	$1.93	$1	$1	$1
Initial operations	38.89	30	35	40
Education grants	15	13	14	15
Financial distress	13.5	25	25	25

Note: These new authorizations begin with the coming fiscal year.

6. Rape Prevention Programs (authorized):

	Millions
Fiscal year 1978	$7.088
Fiscal year 1979	8.0
Fiscal year 1980	9.0
Fiscal year 1981	10.0

7. Provides grants for Mental Health Services which combines past support under Sec. 314(d) with planning money.

	Millions
Fiscal year 1979	$21
Fiscal year 1980	25
Fiscal year 1981	28

8. Totals—(in millions):

a. 1979—$935.4 (Items 1, 4, 5, 6, 7).

b. 1980—$929.5 (Items 2 through 7).

Figures for 1980 do not include future extensions of the Comprehensive Health Services detailed in Item 1.

c. 1981—$1,071.5 (Items 2 through 7).

Figures for 1981 do not include future extensions of the Comprehensive Health Services detailed in Item 1.

d. 1982—$500—two programs are extended through 1982 (Items 2 and 3).

e. Total for whole bill—$3,436.4. Assuming, however, that Item 1 costs remained at about $500 million for each of fiscal year 1980 and 1981, those years would cost $1,429.5 and $1,571.5 respectively, which added to 1979 total of $935.4 equals $3, 936.4.

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Calendar No. 791

95th Congress } SENATE { Report
2d Session } { No. 95-860

HEALTH SERVICES EXTENSION AND PRIMARY HEALTH CARE ACT OF 1978

May 15 (legislative day April 24), 1978—Ordered to be printed

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Mr. Kennedy, from the Committee on
Human Resources, submitted the following

REPORT

[To accompany S. 2474]

The Committee on Human Resources, to which was referred the bill (S. 2474) to amend the Public Health Service Act to extend through the fiscal year ending September 30, 1983, the assistance program for community health centers, migrant health services; to extend through the fiscal year ending September 30, 1981, hemophilia, home health services; to extend through the fiscal year ending September 30, 1979, the assistance programs for comprehensive public health services, hypertension programs, disease control programs, veneral disease programs, genetic diseases programs, and lead-based paint programs, and for other purposes, having considered the same, reports favorably thereon with an amendment to the text and an amendment to the title and recommends that the bill (as amended) do pass.

I. Summary of Legislation

As approved by the committee S. 2474:

(1) Extends through the fiscal year ending September 30, 1979, without major substantive modification, the assistance programs under

reduction in health services offered by the center while the conversion is being planned or occurring, or as a result of the conversion.

The 5-percent limitation on spending of migrant health funds for prepayment does not refer in any way to centers, projects or contracts presently financing the delivery of care through a prepaid capitation mechanism, but refers only to the funding of centers which will offer health services on a prepaid basis as a result of conversion financed through this authorization.

Environmental services

The committee has added a provision relating to modification of private property, incidental to providing environmental health services. This is necessary because, under present Federal regulations, modifications cannot be made to privately owned property unless specifically authorized. However, it is specified in Senate Report 94–29 that centers and projects are required to work through all available Federal, State, and local enforcement and environmental programs to obtain a solution to environmental health problems. If these efforts do not produce a solution to the particular environmental health problem, and if the problem is of serious concern or if there is an immediate health or safety hazard which needs to be corrected, use may be made of migrant health funds for the purposes of making the necessary improvements.

Technical assistance

In providing technical assistance under this program the Secretary may contract for services which will assist and support a number of centers and projects within a region of the country in operating programs under this authority. Specifically, projects which track migrants through their migration or which attempt to centralize and coordinate medical records for migrants are considered technical assistance within the intent of this authority.

Hospitalization

S. 2474 substantially increases the authorization of funds to meet the inpatient care needs of the nation's migrant farmworker population. At present, such services are available only to high risk mothers and infants. Migrant hospitalization is a critical unmet need and under past funding restrictions HEW has been able to defray less than 5 percent of migrant hospitalization needs each year. Migrants are frequently deprived of care in hospitals because they do not have health care plans provided by their employers, they are not able to meet medicaid residency requirements in many States, and the number of hours they work excludes them from medicaid eligibility during the 9- to 10-month season during which they are employed. The committee expects that this increase in authorization will double the number of migrant health centers able to provide hospitalization services and thereby increase the access of migrant and seasonal workers to necessary hospital care.

Medicaid eligibility

Title XIX of the Social Security Act establishes medicaid eligibility for individuals receiving categorical assistance through other titles under the act (section 1902(a)(13)) and prohibits the Secretary from approving a State plan which conditions eligibility on any residence requirement (section 1902(b)(3)). The Secretary by regulation has provided that "a resident of a State is one who is living in the State voluntarily with the intention of making his home there and not for a temporary purpose."

While the conformity of the regulation to the underlying statute may be questioned, some States have interpreted this regulation to impose a requirement of "domicile" rather than "residence" as a condition of medicaid eligibility. The committee understands that "domicile" refers to a family's legal, principal and permanent home while "residence" refers to a family's actual place of abode. Confusion between the two terms has caused uncertainty and inappropriate rulings on eligibility, especially in the context of migrant families who may reside at considerable distances from their domicile for extended periods. The committee anticipates that the Secretary will clarify any uncertainty at the State level in the application of the medicaid prohibition to residency requirements.

Community health centers

	Millions
Actual, fiscal year 1977	$230.148
Estimate, fiscal year 1978	262.0
Authorization, fiscal year 1978	262.9
HEW budget requested, fiscal year 1979	[1] 286.0
Committee recommendation, fiscal year:	
1979	330.0
1980	362.0
1981	397.2
1982	435.9
1983	478.5

[1] Excludes request for research and development (HURA) programs authorized under another section of the Senate bill.

Program extension

In 1975, Congress enacted Public Law 94–63 which was identical to a bill which had been pocket vetoed by President Ford a few months earlier, at the end of the 93d Congress. In the report accompanying S. 66 (Report No. 94–25, March 6, 1975) the committee responded in detail to the issues which had been raised by the Presidential pocket veto of the bill. In particular, the committee noted that its purpose in repealing section 314(e) and replacing it with separate categorical authorities was to give Congress the prerogative of establishing the structure of programs. Section 330 (now being redesignated as section 372) which established a distinct authority for community health centers, accordingly established highly specific criteria concerning the goals, organization, services, and target populations which it intended community health centers to serve.

The committee is generally pleased by the achievements of community health centers in the subsequent 3 years and the improvement in management and efficiency which have been achieved. Indeed, despite relatively stable funding in this period the program has significantly expanded the number of centers and the number of people served by these centers. Nevertheless, the program is only able to reach less than 10 percent of the 49 million people living in medically underserved areas, and only 164 of 544 centers are delivering truly comprehensive services. Because the committee is pleased by the current status of the community health center program and views it as an outstanding *demonstration projects in primary health care; and for other purposes.*

Provisions of S. 2474 which amend laws other than the Public Health Service Act:

NATIONAL SICKLE CELL ANEMIA, TAY-SACHS AND GENETIC DISEASE ACT

* * * * * * *

Title IV—Genetic Diseases

Sec. 402. In order to preserve and protect the health and welfare of all citizens, it is the purpose of this title to establish a national program to provide for basic and applied research, research training, testing, counseling, and information and education programs with respect to genetic diseases, [including sickle cell anemia, Cooley's anemia, Tay-Sachs disease, cystic fibrosis, dysautonomia, hemophilia, retinis pigmentosa, Huntington's chorea, and muscular dystrophy.] *"and genetic conditions, such as Sickle Cell anemia, Cooley's anemia, Tay-Sachs disease, cystic fibrosis, dysautonomia, hemophilia, retinitis pigmentosa, Huntington's chorea, muscular dystrophy, and genetic conditions leading to mental retardation or mental illness, and conditions requiring genetic services."*

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PUBLIC LAW 91-695—LEAD-BASED PAINT POISONING PREVENTION ACT

* * * * * * *

Title V—General

APPROPRIATIONS

Sec. 503. (a) There are authorized to be appropriated to carry out this Act $10,000,000 for the fiscal year 1976, $12,000,000 for the fiscal year 1977, [and] $14,000,000 [for fiscal year 1978] *for the fiscal year ending September 30, 1978, and $14,000,000 for the fiscal year ending September 30, 1979.*

PUBLIC LAW 94-63 HEALTH SERVICES EXTENSION ACT OF 1973

Title VI—Miscellaneous

HOME HEALTH SERVICES

[Sec. 602. (a)(1) For the purpose of demonstrating the establishment and initial operation of public and nonprofit private agencies (as defined in section 1861(o) of the Social Security Act) which will provide home health services (as defined in section 1861(m) of the Social Security Act) in areas in which such services are not otherwise available, the Secretary of Health, Education, and Welfare may, in accordance with the provisions of this section, make grants to meet the initial costs of establishing and operating such agencies and expanding the services available through existing agencies, and to meet the costs of compensating professional and paraprofessional personnel during the initial operation of such agencies or the expansion of services of existing agencies.

(2) In making grants under this subsection, the Secretary shall consider the relative needs of the several States for home health services and preference shall be given to areas within a State in which a high percentage of the population proposed to be served is composed of individuals who are elderly, medically indigent, or both.

(3) Applications for grants under this subsection shall be in such form and contain such information as the Secretary shall prescribe by regulation.

(4) Payment of grants, under this subsection may be made in advance or by way of reimbursement or installments as the Secretary may determine.

(5) There are authorized to be appropriated $8,000,000 for fiscal year 1976, $2,000,000 for the period July 1, 1976 through September 30, 1976, and $8,000,000 for the fiscal year ending September 30, 1977. And $4,000,000 for the fiscal year ending September 30, 1978 for payments under this subsection.

(b) (1) The Secretary of Health, Education, and Welfare may make grants to public and nonprofit private entities to assist them in demonstrating the training of professional and paraprofessional personnel to provide home health services (as defined in section 1861(m) of the Social Security Act).

(2) Applications for grants under this subsection shall be in such form and contain such information as the Secretary shall be regulations, prescribe.

(3) Payment of grants under this section may be made in advance or by way of reimbursement, or installments, as the Secretary shall determine.

(4) There is authorized to be appropriated $2,000,000 for fiscal year 1976, $1,000,000 for the period July 1, 1976 through September 30, 1976, and $4,000,000 for the fiscal year ending September 30, 1977 for payments under grants under this subsection.]

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95th Congress
2d Session
HOUSE OF REPRESENTATIVES
Report
No. 95–1799

HEALTH SERVICES AND CENTERS AMENDMENTS OF 1978

October 15 (legislative day, October 14), 1978.—Ordered to be printed

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Mr. Staggers, from the committee of conference,
submitted the following

CONFERENCE REPORT

[To accompany S. 2474]

The committee of conference on the disagreeing votes of the two Houses on the amendments of the House to the bill (S. 2474) to amend the Public Health Service Act to extend trough the fiscal year ending September 30, 1981, the assistance program for community health centers and migrant health services; assistance to venereal disease programs; genetic diseases programs; hemophilia programs; home health programs; and to extend through the fiscal year ending September 30, 1979, the assistance programs for comprehensive public health services; hypertension programs; disease control programs; lead-based paint poisoning programs; and to establish hospital-affiliated primary care centers; to provide for research and demonstration projects in primary health care; and for other purposes, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the Senate recede from its disagreement to the amendment of the House to the text of the bill and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the House amendment insert the following:

SHORT TITLE; REFERENCE TO ACT

Section 1. (a) This Act may be cited as the "Health Services and Centers Amendments of 1978".

(b) Except as otherwise specifically provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Public Health Service Act.

TITLE I—HEALTH CENTERS AND PRIMARY HEALTH CARE

PART A—MIGRANT HEALTH CENTERS AND COMMUNITY HEALTH CENTERS

SHORT TITLE

SEC. 101. This part may be cited as the "Migrant and Community Health Centers Amendments of 1978".

REDESIGNATION OF MIGRANT HEALTH CENTERS PROVISION

SEC. 102. (a) Section 319 is redesignated as section 329 and is transferred and inserted before section 330.

(b)(1) Section 217(g) is amended by striking out "319" and inserting in lieu thereof "329" each place it appears.

(2) Section 6(b) of the Health Maintenance Organization Act of 1973 (Public Law 93–222) is amended by striking out "310" and inserting in lieu thereof "329".

(3) Section 1903(m)(2)(B)(i) of the Social Security Act is amended by striking out "section 319(d)(1)(A)" and inserting in lieu thereof "section 329(d)(1)(A)".

AMENDMENTS TO MIGRANT HEALTH CENTERS PROGRAM

SEC. 103. (a)(1)(A) Paragraph (1) of subsection (a) of section 329 (as redesignated by section 102(a) of this part) is amended by inserting "(as determined by the centers)" after "as may be appropriate for particular centers" in subparagraphs (D) and (E).

(B) Subparagraph (G) of such paragraph is amended to read as follows:

> *"(G) information on the availability and proper use of health services and services which promote and facilitate optimal use of health services, including, if a substantial number of the individuals in the population served by a center are of limited English-speaking ability, the services of appropriate personnel fluent in the language spoken by a predominant number of such individuals,".*

(C) Such paragraph is further amended by inserting the following before the period at the end thereof: "and individuals who have previously been migratory agricultural workers but can no longer meet the requirements of paragraph (2) of this subsection because of age or disability and members of their families within the area it serves".

(2) Paragraph (6) of such subsection is amended (A) by striking out "and" at the end of subparagraph (E), (B) by striking out the period at the end and inserting in lieu thereof "; and", and (C) by inserting after subparagraph (F) the following new subparagraph:

> *"(G) Pharmaceutical services, as may be appropriate for particular centers.".*

(3) Paragraph (7) of such subsection is amended—

(A) by striking out "(including nutrition education and social services)" in subparagraph (K) and inserting in lieu thereof "(including, for the social and other nonmedical needs which

coordination and consultation with the Deputy Assistant Secretary for Population Affairs, deleting the requirement concerning parental notification, and reducing the levels of authorizations of appropriations to $50 million for fiscal year 1979, $65 million for fiscal year 1980, and $75 million for fiscal year 1981 for the program in titles VI and VII.

Harley O. Staggers,
Paul G. Rogers,
David Satterfield,
Richardson Preyer,
James H. Scheuer,
Tim Lee Carter,
James T. Broyhill,
Managers on the Part of the House.

Edward M. Kennedy,
Gaylord Nelson,
Claiborne Pell,
William Hathaway,
Harrison A. Williams,
Richard S. Schweiker,
Jacob K. Javits,
John H. Chafee,
Alan Cranston,
Managers on the Part of the Senate.

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